

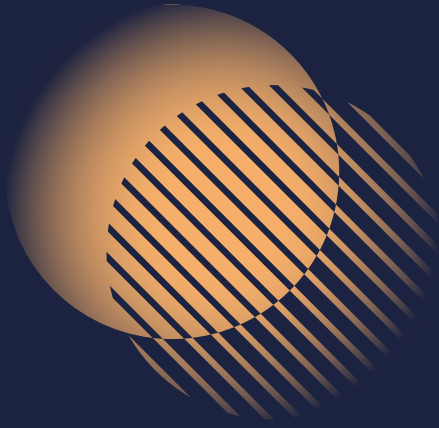


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An investigation into the perceived enablers and barriers to mainstream schooling: The voices of children excluded from school, their caregivers and professionals

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Commissioned by Together for Children, Sunderland

March 2020



**University of
Sunderland**

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Executive summary

The University of Sunderland was approached by Together for Children in Autumn 2018 to 'investigate the factors that impact upon social and emotional wellbeing of children and young people, from 3-16 years in Sunderland City, which may lead to exclusion from school'. The purpose was to provide a research-informed review of mainstream schooling in the City, through a detailed examination of the personal lived experiences of children and their caregivers who experienced exclusion from school. The research also elicited the perceptions and experiences of other stakeholders across health, education and support services on the enablers and barriers to mainstream education for children vulnerable to school exclusion.

In total, 174 participants were interviewed for this research. This included: 55 children, 41 of their caregivers, 69 education professionals including head teachers from nursery to secondary age phase and 14 Special Educational Needs Coordinators (SENCOs) and class teachers. The sample also included nine health and support professionals and three separate advisory groups, consisting of 12 children, five professionals from health/support services and five education professionals.

This is the most substantial piece of primary research carried out to date on the enablers and barriers to mainstream schooling for those at risk of school exclusion in England. It would not have been possible without the commission from Together for Children (TfC), who must be commended for their ambition to improve the lives and schooling experiences of children across the City.

What is evident from this research is that when the caregivers sent their child to school, they did not foresee the difficulties that lay ahead. The reality is that for some of the children in this study, the mainstream model of schooling didn't work. They reported barriers to accessing the curriculum and participating in learning due to a multitude of factors outside of their control, including academic expectations and curriculum, large class sizes and unidentified

learning and health needs. They also shared experiences of failed relationships with teachers and a need for more holistic support than was available. Some participants suggested that inflexible behaviour sanctions, including being placed in isolation booths, where predominantly, no teaching or learning occurred, were a barrier to mainstream school.

The overarching aim

To investigate the factors that impact upon social and emotional wellbeing of children and young people from 3-16 years in Sunderland Local Authority, which may lead to exclusion from school.

Objectives

- To elicit the perceptions and experiences of excluded children, their caregivers and professionals, around the barriers and enablers to mainstream schooling
- To determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream-school
- To evaluate the effectiveness of national policy in supporting children to remain in mainstream school
- To produce a report with supporting evidence to inform provision planning and training for education professionals within the local area of Sunderland

Recommendations

The recommendations in this report are intended to enable the local area to develop expertise and capacity in schools to allow children to thrive emotionally and socially. Implementing these recommendations will require a shared

Recommendation 1: We think isolation booths should be removed from all schools as they do not work and do not improve behaviour but make it worse.

Recommendation 2: We need smaller class sizes in mainstream schools, 30 in a class is too noisy, there is too much distraction and teachers cannot give us the help we need, this will help us learn.

The following recommendations are from the interviews, conversations and advisory group comments.

Recommendation 3: Governing bodies must work with senior leaders and SENCOs to embed alternative approaches to isolation booths that are based on child-centred approaches. This needs to include training, so there is a clear understanding of the need to apply the graduated approach of: assess, plan, do and review (DfE, 2015a) to identify, understand and respond to children's needs through evidence-based practices.

Recommendation 4: Schools should access training to reinforce their reasonable adjustment duties as legally required by the Equality Act 2010 and obligations within the Children and Families Act 2014. These need to be made explicit in school policies such as SEND, safeguarding, equality, behaviour/discipline, positive handling, mental health and looked after and previously looked after children.

Recommendation 5: Schools should access training on alternative and child-centred approaches to restraining children. For example, Studio 3's Managing Challenging Behaviour course (MCB), accredited by the British Institute of Learning Disabilities. This needs to include the impact of traumatic Adverse Childhood Experiences (ACEs) on children's mental health and wellbeing.

Recommendation 6: For stakeholders in key stage 2, secondary education and TfC to explore the adoption of a vocational education and training model for children who have aspirations outside of academic routes and/or who find the current curriculum stressful and unmanageable. With agreement from the caregiver and child, there should be consideration of continuing the primary education model into years 7 and 8 for those children who have been identified as needing an alternative route within secondary mainstream education.

Recommendation 7: Review of health services pathways, including the introduction of a health and support services triage service in Sunderland for children across the child and adolescent years. This would ensure that a health professional decided which pathway is most suitable for the child or young person (paediatric disability service, community CAMHS or CYPS), or other support services. This will need to include a review of the procedures for responding to caregiver concerns at the two-year progress check.

Recommendation 8: To immediately revoke the child and adolescent mental health service CAMHS special circumstances list so that all children can access timely support.

Recommendation 9: Children on the edge of or allocated a fixed-period or permanent exclusion should be referred to health services to determine any underlying genetic, learning disabilities or neurodiversity causes.

Recommendation 10: To provide training to health visitors to ensure there is consistency in how the teams recognise and respond to the caregiver's voice when they share concerns about their child's development and/or behaviours.

Recommendation 11: To create a crisis response team as part of the CYPS service, to be available to schools from 8 am until 5 pm to allow for issues arising before, during and after school.

Recommendation 12: Further consideration to be given across the health services of the consequences when a child fails to attend an appointment, or is unable to communicate during the meeting. The paediatric disability consultants should lead this, as they were commended for their procedures and practices.

National recommendation: Department for Education (DfE) must take steps to address the use of isolation booths in schools. They should review guidance on the use of this method of sanction and commission case studies of alternative child-centred approaches.

I am grateful to all the participants who took part in this research and openly shared their experiences. Thank you for your time and your stories you have been honest and sincere, and this will allow the local area to move forward with research-informed evidence. I would particularly like to thank the children and caregivers; being able to hear from you directly has been fundamental to this research. You are all brave and inspirational, and I wholeheartedly wish you the best life.

Sarah Martin-Denham
March 2020

Sarah Martin-Denham: Principal Investigator, Project Director and Author



Sarah is a Senior Fellow of the Higher Education Academy, a Vice-Chancellor Teaching Fellow, Chair of an independent SENCO network and a Convenor of an Interdisciplinary Research Network for developing knowledge, understanding and approaches for supporting children who are experiencing adverse childhood experiences. She has extensive knowledge of learning and teaching in the North East of England, in a variety of settings, from Early Years to Higher Education. Sarah has successfully developed and led four programmes and research projects in the School of Education at the University of Sunderland, and is the Programme Leader for the National Award for Special Educational Needs Coordination. Through her work with children and families over the last twenty years and her neurodiverse abilities, she has developed a particular interest in Special Educational Needs and disabilities.

Recent Publications:

Martin-Denham, S. and Donaghue, J. (written for submission) 'The impact and measure of Adverse Childhood Experiences: Reflections of undergraduates and graduates in England.'

Martin-Denham, S. (2020) 'A review of school exclusion on the mental health, well-being of children and young people in the City of Sunderland.' Sunderland: University of Sunderland.

Martin-Denham, S. (2020) 'The enablers and barriers to successful managed moves: The voice of children, caregivers and professionals.' Sunderland: University of Sunderland.

Martin-Denham, S. and Donaghue, J. (2020) 'A review of fixed-period and permanent school exclusions in children with SEN and no SEN designation in the City of Sunderland.' Sunderland: University of Sunderland.

Martin-Denham, S. and Donaghue, J. (2020) 'What is the prevalence of primary and secondary types of Special Educational Needs (SEN) in the City of Sunderland? A national comparative analysis of school census data.' Sunderland: University of Sunderland.

Martin-Denham, S. and Donaghue, J. (2020) 'Excluding children for no real reason: What is the extent of the use of the category 'other' in school census returns in England? A Policy Brief.' Sunderland: University of Sunderland.

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Glossary of acronyms

ACE Adverse Childhood Experience	DfE Department for Education
ADHD Attention Deficit Hyperactivity Disorder	DoH Department of Health
AP Alternative Provision	DSM-5 Diagnostic and Statistical Manual of Mental Disorders
APVA Adolescent to Parent Violence and Abuse	EHCP Education, Health and Care plan
ASD Autism Spectrum Disorder	EYFS Early Years Foundation Stage
BERA British Educational Research Association	GDPR General Data Protection Regulation
BILD British Institute of Learning Disabilities	GP General Practitioner
CAMHS Child and Adolescent Mental Health Services	HIV Human Immunodeficiency Virus
CAPBS Centre for the Advancement of Positive Behaviour Support	IPSEA Independent Parental Special Education Advice
CCG Clinical Commissioning Group	ITE Initial Teacher Education
CCVAB Children with Challenging, Violent or Aggressive Behaviour	LA Local Authority
CPV Child to Parent Violence	MLD Moderate Learning Difficulty
CVAB Challenging, Violent and Aggressive Behaviour(s)	NC National Curriculum
CYPS Children and Young People's Services	NCTL National College for Teaching and Leadership
	NEET Not in Education, Employment or Training

NHS National Health Service	SENCO Special Educational Needs Coordinator
OCD Obsessive-Compulsive Disorder	SEND Special Educational Needs and/ or Disability
OECD Organisation for Economic Co-operation and Development	SEP Special Educational Provision
Ofsted Office for Standards in Education	SLCN Speech, Language and Communication Needs
PTSD Post-Traumatic Stress Disorder	UNESCO United Nations Educational, Scientific and Cultural Organization
SEN Special Educational Needs	

Glossary of terms

Alternative provision: For children of compulsory school age who do not attend mainstream or special schools

Annual review: The review of an EHC plan, which the Local Authority must make every 12 months as a minimum

Care pathway: The route a person takes through healthcare services

Depression: Where an individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy, leading to increased fatigability and diminished activity

Designated teachers: Champion the educational attainment of looked-after and permanently placed children

Diagnosis: The process of identifying an illness by carrying out tests or by studying the symptoms

Early years foundation stage: The framework for the learning, development and care of children from birth to five years

Education health and care plan: Details the education, health and social care support to be provided to a child with SEN and/or disabilities

Graduated response: A model of action and intervention to support children who have SEN

Local authority: Leading integration arrangements for children with SEND

Maintained school: Schools that are maintained by a Local Authority

Methodology: Describes how research is carried out, including how information is collected and analysed, and why a particular method or methods have been chosen

National curriculum: Statutory entitlement to learning for all children from 5-16 years

NHS England: An independent body that aims to to improve health outcomes for people in England

Official exclusions: These are recorded with central or local government and include temporary fixed period exclusions or permanent exclusions

Ofsted: Responsible for the inspection of all schools in England

Prevalence: How common a type of exceptionality is within a population, either at a point in time or over a given period of time

Prognosis: The medical assessment of the future course and probable outcome of an illness

Pupil referral unit: Provides education for children who would otherwise not receive suitable education because of illness, exclusion or any other reason

Schizophrenia: A severe mental health disorder, characterised by a loss of reality

SEN support: Extra or different support provided in addition to the school's usual curriculum

Social care: All forms of personal care and other practical assistance for children who need extra support

Special educational needs: A child has an SEN if they have a learning difficulty or disability which calls for special educational provision to be made

Special Educational Needs Coordinator: A qualified teacher in a school or maintained nursery school who has responsibility for coordinating SEN provision

Special educational provision: Provision that is different from, or additional to, that which is normally available to children with SEN, to enable them to access and participate in learning

Stakeholder: An organisation/individual with an interest in a topic, including public sector providers and commissioners of care or services

Statutory duty: A duty that must be complied with

Unofficial exclusions: These are not recorded as exclusions in the national data and include managed moves to a different school; a move into some form of alternative provision offsite; or illegal exclusions

Young person: A person over compulsory school age (the end of the academic year in which they turn 16 to the age of 25)

For ease of reading:

- 'Children' will be used to refer to children and young people
- 'Caregiver' for all of those with guardianship of children
- 'School' will be used to refer to any educational establishment
- 'Code' will be used for reference to the special educational needs and disability code of practice (DfE, 2015a)
- 'Mainstream school' relates to the following schools: maintained, academies, free and faith schools

1. Introduction

1. Introduction

1.1. Rationale for the report

Together for Children (TfC) commissioned this research in response to the Martin-Denham et al. (2017) report, which highlighted higher than the national prevalence of particular primary types of special educational needs (SEN). It reported that in 2016, the number of children with an education, health and care plan (EHCP) with social, emotional and mental health (SEMH) as their primary type of need was 14.03% higher than the national rate. TfC wanted to find out the factors that may have led to this rise, with a particular focus on those children who received fixed and/or permanent exclusions from school. The findings and recommendations will be used by TfC and Sunderland City Council to inform the strategic plan for the next five years. They want to use research as a tool to progress and reform how services are commissioned and to reconfigure inclusion for children with special educational needs and disabilities (SEND).

1.2. Context: Sunderland

The City of Sunderland, lies on the North East coast of England, and has a long and illustrious history of shipbuilding, heavy engineering and glass-making (Short and Fundinsland-Tetlow, 2012). Sunderland lies at the mouth of the River Wear, one of the principal waterways in the region's second largest City. The south of the river is the most populated area of Sunderland (Dodds, 2011).

Over time, Sunderland has grown from being a small trading port into a large industrial City due to rural-urban migration within the region, high birth rates and historic immigration from Ireland and Scotland (Cookson, 2015). The 2011 census (Nomis, 2019) states that the total number of residents in Sunderland was 275, 506, with 39.9% of households having no adults currently in employment.

1.3. Research question

What are the enablers and barriers to mainstream schooling for children at risk of school exclusion in the City of Sunderland?

1.4. Aims and objectives

The project had the following aim and objectives:

Aim

To investigate the factors that impact on social and emotional wellbeing of children and young people, from 3-16 years in Sunderland Local Authority, which may lead to exclusion from school.

Objectives

- To elicit the perceptions and experiences of excluded children, their caregivers and professionals, of the barriers and enablers to mainstream schooling
- To determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream school
- To evaluate the effectiveness of national policy in supporting children to remain in mainstream school
- To produce a report, with supporting evidence, to inform provision planning and training for education professionals within the local area of Sunderland

2. Literature Review

2. Literature review

The literature review explores key themes that relate to the rights of children with SEND. This begins with setting the context in terms of legislation and policy. It then discusses different aspects that impact negatively on some children's ability to access school due to the barriers to learning some children experience.

The Children and Families Act (CAFA) (2014) part 3 provides the current legislation for children with SEND from 0-25 years in England. It sets out a legal duty for health, education and care to work collaboratively as a joined-up approach for the benefit of families and children; it is legally binding, so schools and Local Authorities (LAs) must comply with their duties. The SEND regulations (DfE, 2014a) are the main set of regulations that underpin this legislation. The following principles in the CAFA (2014) are of paramount importance:

- Taking into account the views of children and their caregivers
- The child and their caregivers participating as fully as possible in decisions and in being provided with the information and support needed to enable them to participate
- The need to support the child and their caregivers, to facilitate their development to achieve the best possible educational and other outcomes, preparing them adequately for adulthood
- To identify the needs of children and to provide high-quality provision
- To focus on inclusive practice and removing barriers to learning.

Inclusion is inextricably linked to legislation and policy, and where the child is placed. This forms part of the discussion for this study, as it explores whether it is possible for children with SEN to feel and be included while attending mainstream school (Martin-Denham and Watts, 2019). It is widely accepted that

the notion of inclusion and what constitutes inclusive practice is the most controversial issue regarding education of children with SEND (Farrell, 2010; Hornby, 2015; Glazzard, 2015). One complexity is due to the many varying definitions of the term 'inclusion', which incorporates the difference between inclusion and integration (Norwich, 2012). The term 'integration' was introduced by Warnock (Department of Education and Science, 1978), referring to accommodating children with SEN into a common educational framework. The Education Act 1981 created an expectation that a child would be placed in an 'ordinary' school when it did not negatively affect the education of other children, was cost-efficient and accorded with parental preference. It also signalled a move away from the presumption that certain needs would be provided for in specialist schools. This new inclusive model was intended to promote placing a greater number of children within mainstream schools (Lauchlan and Grieg, 2015). At this point, the terminology began to change from 'integration' to 'inclusion' following the United Nations Educational Scientific and Cultural Organisation's (UNESCO) Salamanca Declaration (1994). This statement called on all countries to embed the principle of inclusion into their education policies and practices so that all children could access mainstream school. A widely shared definition from the National Association of Special Educational Needs (NASEN, 1998) is as follows:

'...inclusion is not a simple concept, restricted to issues of placement. Its definition has to encompass broad notions of educational access and recognise the importance of catering for diverse needs. Increasing mainstream access is an important goal. However, it will not develop spontaneously and needs to be actively planned for and promoted'.

Norwich (2017) clarified that the term inclusion was intended to be used to focus on what specific provision the child needed to develop and learn, such as teaching, facilities, materials and support; not the difficulties the child experienced. In 2007, a Conservative Party sponsored commission stated that inclusion was a failed ideology and advocated the use of

separate and specialist provisions, despite many being closed as part of Government policy. A change in Government in 2010 resulted in the Conservative Party endorsing special school provision, giving caregivers a greater choice over choosing schools (DfE, 2011a).

Warnock (2005) has rejected the idea of educating children ‘all under one roof’ instead she supports the importance of children being engaged in a common education experience to learn and develop to the best of their abilities prioritising this over the placement. This was more recently endorsed in the DfE (2015a) Code, which states:

‘Special schools in the maintained, academy, non-maintained and independent sectors, special post-16 institutions and specialist colleges all have an important role in providing for children and young people with SEN and in working collaboratively with mainstream and special settings to develop and share expertise and approaches’ (DfE, 2015a, p. 28)

The DfE (2015a) Code makes little reference to inclusion. However, the National Curriculum (NC) (DfE, 2014b, 4.1) states that ‘a wide range of pupils have special educational needs, many of whom also have disabilities. Lessons should be planned to ensure that there are no barriers to every pupil achieving. In many cases, such planning will mean that these pupils will be able to study the full national curriculum’ (DfE, 2013a, p.8).

Inclusion is seen as a multi-dimensional concept that celebrates and values difference and diversity with consideration of human rights, social justice and equity; it holds a focus on both a child’s entitlement and access to education (Loreman et al., 2011; Topping, 2012). It is a problematic concept as it is used in different ways; either in reference to inclusive schools or inclusive societies, or from a policy level, more children in mainstream schools (Terzi, 2010). The notion of ‘full inclusion’ education in these schools is impossible to achieve as the provision is not the right environment for all children (Hansen, 2012; Kauffman and Badar, 2014). This creates tension between a child’s fundamental

right to be educated alongside their mainstream peers (Hornby, 2015) and their human right that it is not, for some, morally the best option (Terzi, 2010).

2.1. What are special educational needs (SEN)?

A SEN is defined as:

- A child or young person who has a learning difficulty or disability which calls for special educational provision to be made for him or her.
- A child of compulsory school age or a young person has a learning difficulty or disability if he or she:
- has significantly greater difficulty in learning than the majority of others of the same age

or

- has a disability that prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions (DfE, 2015a).

The reality is that there are issues with the term SEN, including variability in how it is identified, interpreted and assessed, due to varying interpretations of its meaning (Ellis and Tod, 2012; Martin-Denham and Watts, 2019). This will inevitably lead to inconsistencies in levels of support received across education provisions within local authorities and across the country.

2.2. Numbers of children in England with special education needs and disabilities

The National Audit Office (NAO) (2019) reports that 1.3 million pupils in England were identified as having SEND at the end of January 2019. They clarify that these children have diverse needs of different levels of severity and they may have more than one type of difficulty. The most commonly identified primary SEND nationally are: Speech, Language and Communication Needs (SLCN) (21.7% of pupils with SEND at January 2019) and Moderate Learning

Difficulties (MLD) (20.4%). Significantly more boys than girls are identified as having SEND – 20.2% of boys aged 5 to 17 in state-funded schools in January 2019, compared with 10.7% of girls.

There are fewer children with SEN attending mainstream provision nationally, with 83.9% attending mainstream education in 2015/16, decreasing to 82.9% in 2017/18. This meant that in 2017/18, approximately 10.3% of children designated with SEN were enrolled in alternative provision and maintained or non-maintained special schools; representing an increase of 0.6% from 2015/16.

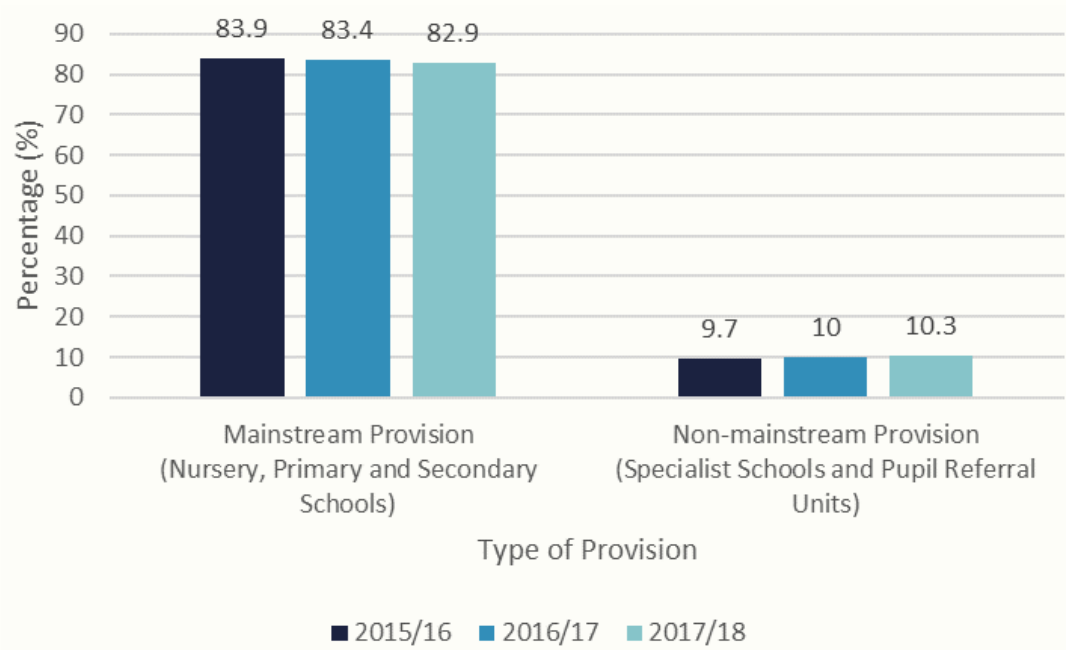


Figure: 1. Percentage of children designated as SEN in mainstream and non-mainstream provision (2015/16 - 2017/18).

2.3. What is a disability?

The Code (DfE, 2015a) shares a definition of disability that draws upon the Equality Act (2010). This explains that children have a disability if they present with ‘a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities’ (p. 16). This definition provides a relatively low threshold for disability and includes more children than many realise: ‘long-term’ is defined as ‘a year or more’ and ‘substantial’ is defined as ‘more than minor or trivial’ (Martin-Denham and Watts, 2019). The following needs are automatically treated as a disability under the Equality Act (2010): cancer, HIV, multiple sclerosis, severe disfigurement and and certified blind or having severe vision challenges as confirmed by a consultant ophthalmologist. For other physical and mental health conditions, it depends on the effect on daily life and includes:

- Sight or hearing
- Heart disease and asthma
- Learning disabilities
- Learning differences such as dyslexia and dyspraxia
- Autism
- Depression, schizophrenia, bipolar affective disorders, eating disorders, obsessive-compulsive disorders.
- Difficulties due to brain injury

If a child with a disability also requires special educational provision (SEP), they will also be covered by the SEN definition.

2.4. Special educational needs support and education health and care plans

The National Audit Office (NAO) (2019) note that nationally, on January 2019, 20.6% of children had legally enforceable entitlements to packages of support, which were set out in EHC plans. Almost half of these (47.9%) attended mainstream schools. Likewise, 79.4% of children with SEND did not have an EHC plan but were identified as accessing additional support (SEN support), most of these (91.6%) attended mainstream schools.

2.5. Outcomes for children with special educational needs and disabilities

Underlying issues identified by Ofsted (2018) are that many EHC plans are not successfully implemented, so gaps in outcomes between those with and without an EHC plan continue to widen. They also report that identification of SEN is weak and those who do not meet the threshold for an EHC plan are more likely to have negative outcomes. The report also emphasised that in 30 local area inspections, children on SEN support did not benefit as consistently as those with an education, health and care plan (EHCP). DfE (2018) agreed, reporting that outcomes for young people with SEND are often poor. In 2016/17, the Progress 8 score for those on SEN support was -0.43 and for those with a statement or EHC plan, it was -1.04. Fewer 16-17-year-olds with SEN (87%) than without (92%) are in education or training (DfE, 2018). Figure 2 shows that children attending local authority maintained schools have an average attainment eight score of 46.5, the third highest behind converter academies (50.2) and free schools (48.9).

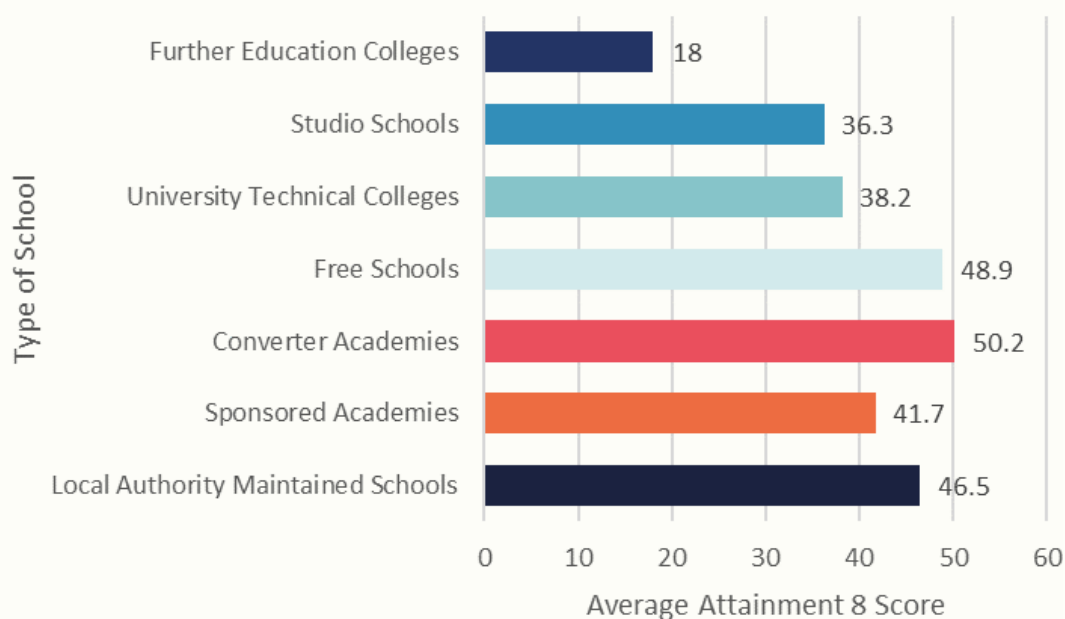


Figure: 2. Average Attainment 8 score across different types of school

2.6. Funding for children with special educational needs and disabilities

An estimated £3.8 billion of ‘schools block’ funding was explicitly spent to support children with SEND in mainstream schools (NAO, 2019). This was not ring-fenced but the expectation was that schools would use this money to cover the first £6,000 of support per pupil with SEND (Martin-Denham and Watts, 2019). In addition, £5.6 billion of ‘high needs block’ funding pays for places in specialist and alternative provision, and gives top-up funding for mainstream schools for the costs above the £6,000 per-pupil threshold. High needs funding has fallen in real terms due to a 10% increase in the number of children in specialist provision (NAO, 2019).

2.7. Special Educational Needs Coordinators (SENCOs)

Maher and MacBeath (2014) suggest that one outcome of the commitment to the UNESCO (1994) inclusive education policy was to increase the number of children with SEN being taught in mainstream schools, which made SENCOs increasingly part of the

school culture. The Code requires governing bodies of maintained mainstream schools and proprietors of academies and free schools to ensure there is a qualified teacher designated as SENCO (DfE, 2015a). Their role should be strategic, overseeing the day to day operation of the SEND policy, coordinating provision, supporting colleagues with professional guidance, advocating for caregivers and children, and being a point of contact for external agencies (DfE, 2015a). In a 2018 survey, 74% of coordinators reported that they did not have enough time to ensure those on SEN support could access the support they needed, and 70% did not feel they had enough time allocated to the role (NASEN, 2018). One of the challenges of being a SENCO is that the Code does not dictate that they must be part of the school leadership team (Martin-Denham and Watts, 2019). This creates barriers to the development of inclusive learning environments and resources allocation due to a lack of authority in school hierarchies (Wedell, 2004; Maher and Macbeth, 2014).

2.8. Teacher training

DfE (2011b) stated in the statutory teachers' standards that teachers must have a clear understanding of the needs of all pupils, including those with special educational needs. In 2014, the Secretary of State for Education asked Sir Andrew Carter to carry out an independent review to identify which core elements of high-quality Initial Teacher Training across phases and subject disciplines are key to equipping trainees with the required skills and knowledge to become outstanding teachers (DfE, 2015b). This and other research has shown that some teachers lack the skills to manage the mental health and wellbeing needs of children (Lebeer et al., 2012; Carter, 2015). The impact of this has been outlined by NAO (2019) who shared caregivers' concerns that mainstream schools were not meeting children's needs and were unable to cope with children's behaviour. In some cases, this led to school exclusion or caregivers withdrawing their child because of concerns about their mental health. The recommendations following the Carter Review were that teacher training providers should ensure trainees understand the SEND Code (DfE, 2015a) and are confident working with the four broad areas of need, including adapting teaching strategies to ensure all children can access the curriculum (DfE, 2016). In light of the issues raised, Ofsted (2018) is focusing on an initial teacher education (ITE) inspection framework with an expectation that it will ensure trainee teachers are well prepared to provide support to all children in education.

In addition, the National Institute of Clinical Excellence (NICE) (2017) produced guidelines for early years, primary and secondary education to promote social and emotional wellbeing. This included planning and delivering programmes and activities to support schools in identifying signs of anxiety or social and emotional problems and how to address them. This guidance also includes recommendations of comprehensive, universal and targeted approaches for use in schools that rely upon teachers and practitioners being trained to identify and assess where a specialist should be involved with a child.

2.9. Barriers to mainstream schooling

The debate about how to support children with diverse abilities to enable them to remain in a mainstream context is ongoing internationally and it is suggested that many variables in school can affect children's ability to learn, including class size, dynamics and the availability of additional adults (Blatchford and Webster, 2018). Evidence presented by Johnson et al. (2017) found that the barriers to providing effective support were resource issues, namely the availability of external professionals. Concerns were also identified with the quality of lessons for children with SEN and the ability of staff to meet their needs. These themes and others will be further explored in this section.

2.9.1. Accountability

The current accountability structures in England were introduced following the Education Reform Act (DES, 1988). Brown and Carr (2019) argue that the introduction of mandatory national Standardised Assessment Tests (SATs), following the Education Reform Act 1988, was intended to measure the variable achievements of children in the core subjects. Schools are still adjusting to systemic changes that reconstructed education as outcomes-oriented and where external judgements of schools are made based on their outcomes (Ball, 2003; Martin-Denham and Watts, 2019). House of Commons (2018b) rightly reports that the education system has been subject to significant change, to qualifications at both primary and secondary phases and with the push for academisation across the country. School budgets are much tighter; the school system has fragmented yet further and is now a national system in name only, as there are seven types of secondary schools in England and Wales (Coffield, 2018). Local Authorities are starved of resources, with budgets effectively cut by around a quarter since 2010 (Smith et al., 2016). Cash welfare benefits have been cut, capped and frozen, with many claimants waiting weeks for payment since the introduction of universal credit (NAO, 2018; Patrick, 2017). Some claimants were sanctioned by halting their payments (Patrick, 2017). All of these

factors are believed to have caused the re-emergence of child poverty and homelessness, which has risen by over 50% since 2010 (Yeung, 2016). Food bank use has grown hugely, with the Trussell Trust providing 1,084,604 food parcels in 2014-15 compared to 40,898 in 2009-10 (Garthwaite, 2016).

Research for the National Union of Teachers (Hutchings, 2015, p. 2) emphasised that the accountability agenda in England has changed the nature of education in wide-ranging and harmful ways. Teaching standard 5 (DfE, 2011b, p.11) states that teachers must adapt teaching to respond to the strengths and needs of all children, and must be able to use and evaluate distinctive teaching approaches to engage and support them. Hutchings (2015) reports findings that teacher workloads are excessive, resulting in increased stress due to the pressure to meet targets for children's attainment. She conveyed children's views that there is a reduction in teacher-pupil interaction, loss of flexibility and lack of time for teachers to respond to children as individuals with increasing pressure for them to do things before they are ready. Wyness and Lang (2016) add that changes to teacher workloads have had significant implications for schools as a social and emotional space, where children can develop as learners, democratic citizens and as emotionally and socially centred individuals.

As illustrated below, responsibility and accountability for the development and progress of children with SEND lie with teachers, not SENCO or support staff.

The Code adds that teachers:

- Are responsible and accountable for the progress and development of the children in their class, including where children access support from support staff or specialist staff
- Should remain responsible for working with the child on a daily basis, even when interventions involve group or one-to-one teaching away from the main class or subject teacher
- Should work closely with any teaching assistants or specialist staff involved, to

plan and assess the impact of support and interventions and how they can be linked to classroom teaching

- Working with the SENCO should revise the support in light of the child's progress and development, deciding on any changes to the support and outcomes in consultation with the caregiver and child

(DfE, 2015a, p. 99, 101, 102).

2.9.2. The testing regime

The National Curriculum (NC) was introduced in 1988 as an assessment-driven system with tests for children from year one to year eleven. Since their introduction account has not been taken of how to assess children with SEN (Norwich, 2017). This is evidenced by the Government taking 13 years to introduce a modified NC for children with learning difficulties through the introduction of P scale assessment for children attaining below level 1 of the NC scale (Martin-Denham, 2015).

The National Teachers' Union Report (2015, p. 5) concluded that 'children and young people are suffering from increasingly high levels of school-related anxiety and stress, disaffection and mental health problems.' ChildLine (2014; 2015) expressed the same views, reporting that school and exam pressures were one of the biggest causes of stress and anxiety among children and young people, noting a 200 per cent increase in counselling sessions related to exam stress between 2012-13 and 2013-14. Hutchings (2015) elaborates that there is increased pressure from tests and greater awareness at younger ages of their own failure due to the increased rigour and academic demands of the curriculum. ATL (2016) share findings that 82% of educators believed children were under more pressure now than ten years ago, with 89% agreeing that testing and exams are the most significant factor. Power and Taylor (2018) suggest that high stakes testing leads to disengagement of children who struggle academically. The House of Commons (2018b) agreed that high stakes exams were a source of pressure and that a reduction in creative and technical subjects meant fewer opportunities for children to express themselves. In comparison to other European countries,

11-16-year-olds in England feel more pressure to do their school work (WHO, 2012).

2.9.3. The vocational/academic divide

The divide between vocational and academic routes has been persistent in the UK education and training sector for a long time (Taylor, 2010; Chankseliani et al., 2016). The reason is that vocational routes are deemed to be inferior to academic pathways, as they attract a disproportionately high number of children from low-income families who may be excluded from mainstream education (Lewis, 1994; Pring et al., 2009; Cabinet Office, 2011). However, the Wolf Report (2011) acknowledged the importance of the vocational subjects in schools within a core curriculum for those aged 14-16 years. Since then, the intellectual and professional nature of vocational education is being recognised due

to the number of medium and high skilled jobs that are considered to be vocational (Clifton et al., 2014).

In Switzerland, vocational education is the preferred route, chosen by approximately two-thirds of a birth cohort (Basler and Kriesi, 2019). Their system is highly stratified and differentiated into a series of routes or tracks which differ based on the level of academic requirement (Buchmann et al., 2016) and links to the labour market (Sacchi et al., 2016). The tracks shown in Fig. 3 begin at age 12 or 13 with different academic requirements. The model is mostly based in business, with trainees spending three to four days a week with a training organisation and two days in vocational school. It offers around 230 training occupations, which are applied for age 14 or 15 (Basler and Kriesi, 2019).

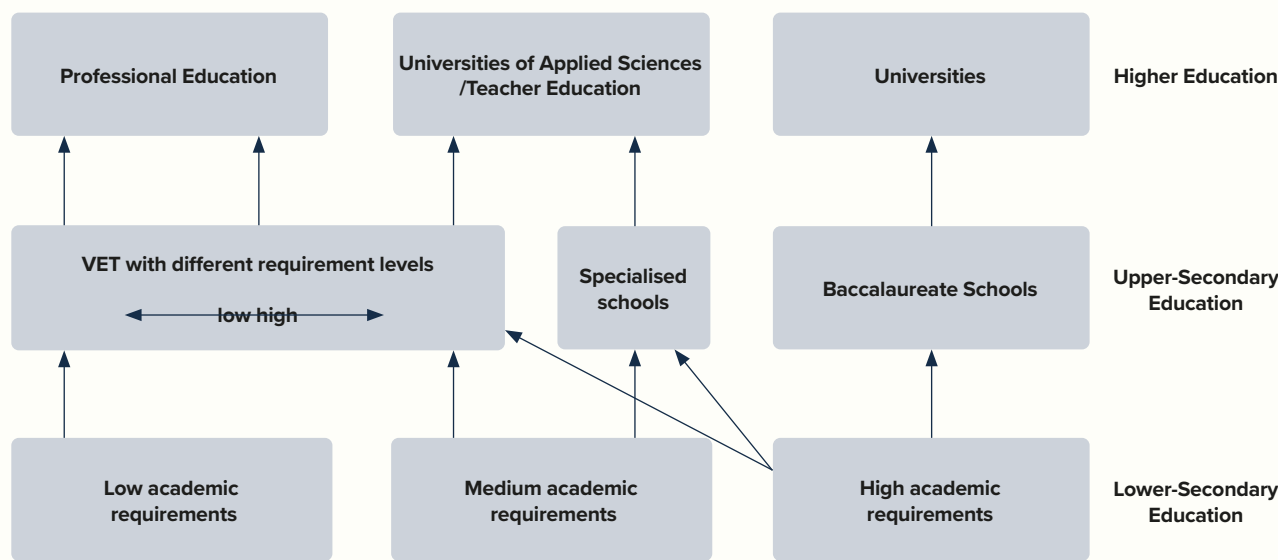


Figure 3. The Swiss education system: The pathways between secondary and higher education (Basler and Kriesi, 2019).

2.9.4 Alternative school models

Duffield (2018) proposes that alternative school models are one way to meet the needs of children who have not succeeded in the traditional school format. Aron (2006) discusses the concept of alternative programming as an approach to support children with multiple and varied needs, such as social and emotional and behavioural difficulties. The characteristics of this approach are small class sizes, teachers with experience in alternative education, a highly structured and collaborative environment and integrated classes (Vann et al., 2000), and links with outside support agencies including mental health providers (Weir, 1996).

2.9.5. Adverse Childhood Experiences (ACEs)

The World Health Organisation (2018a) defines adverse childhood experiences (ACEs) as ‘some of the most intensive and frequently occurring sources of stress that children may suffer in early life. Such experiences include multiple types of abuse; neglect; violence between parents and caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence’. Following exposure to stress, the body’s natural response is to stimulate the sympathetic nervous system, increasing the levels of stress hormones, such as cortisol, and other responses, such as an increase in respiration, heart rate and blood pressure (Dusek and Benson, 2009). When the stressor has been removed, in most cases, this is followed by the activation of the parasympathetic nervous system, acting as a counterbalance (Skonkoff et al., 2011) to return the body to ‘normal’ (Franke, 2014). Prolonged, permanent or extreme exposure to stress can lead to prolonged stress hormone activation, which cumulatively leads to ‘wear and tear’ on organs including the brain (Johnson et al., 2013). This is known as toxic stress and in the absence of supporting adults acting as a buffer, has been linked to physiological changes that can lead to developing poor health outcomes in later life and adolescence.

These include depression, anxiety, sleep disorders, low self-esteem, substance misuse and risky health behaviours (Dunn et al., 2013; Vachon et al., 2015; McKelvey et al., 2017; Thorley and Coates, 2018).

Cooper and Mackie (2016) share that resilience is a positive and adaptive response, which can transform ‘toxic stress’ into ‘tolerable stress’. They also provide evidence from research that one stable and committed relationship from either a supportive caregiver or another adult or peer can reduce stress. An additional protective factor described by Schofield et al. (2018) is community cohesion, which can reduce the impact of ACEs across generations.

2.9.6. Challenging, violent and aggressive behaviour(s) (CVAB)

Thorley and Coates (2018) introduced the term CVAB to encompass a range of previous acronyms used to define children’s behaviour, these included CPV (Child to Parent Violence), APVA (Adolescent to Parent Violence and Abuse), and VCB (Violent Challenging Behaviour). In schools and at home, children can display behaviour that is viewed as challenging, aggressive or violent by those who observe it. Knowing how best to support children with unpredictable behaviours is complex. However, such support is crucial for the health and wellbeing of all concerned (Martin-Denham and Watts, 2019). They discuss that behaviours may arise due to trauma, adverse childhood experiences, bereavement or identified/unidentified special educational needs or learning/physical disabilities. Staff need to be enabled, through training, to understand and manage these behaviours or they will continue or escalate, ultimately leading to both the teacher and the child becoming increasingly distressed.

It is widely understood that children with autism may experience intense anxiety due to difficulties with communication and interaction with teachers and peers. Many factors can lead to increased anxiety, such as being over- and/or under-stimulated, or undiagnosed due to

changes to school timetables or classroom routines or staffing (Martin-Denham and Watts, 2019). They add that if a child is in crisis or there has been an incident involving CVAB, there should be a debrief to see how this could be prevented. However, attempting to debrief with children at the point of the behaviour is unrealistic. It is therefore important to **relate** before any attempt is made to **regulate**. It is important to note that when a child reaches the point of crisis, it means school processes have failed; a need has not been met and this needs to be explored through debriefing systems to plan to prevent future occurrences.

2.9.7. Zero tolerance and non-flexible behaviour policies

As Booth and Ainscow (2011) discuss, developing inclusion involves reducing exclusionary pressures. They use the term ‘disciplinary exclusion’ to refer to the temporary or permanent removal of a child for breaches of school rules. What needs to be understood is that some children have ongoing pressures that prevent them from participating in school life including: dealing with previous or current trauma, or learning challenges, including specific learning difficulties or ongoing unmet needs (Martin-Denham and Watts, 2019). The DfE (2018) reported the evidence from the Timpson Review highlighted a rise in ‘zero tolerance’ behaviour policies which create school environments where children are punished and excluded for incidents that could have and should have been managed within the mainstream school.

During adolescence, there are ‘rapid cognitive, biological and social changes that may increase misbehaviour’ (Amemiya et al., 2019, p. 3). Gregory and Cornell (2009) and Kupchik and Catlaw, (2015) concur that internationally, discipline policies in schools don’t consider or allow normative adolescent behaviours. As part of this developmental stage, children need to establish autonomy from adults, which may involve stepping outside of boundaries (Eccles and Roser, 2013; Bryan et al., 2016). A driver for children in using low-level behaviours can be to gain acceptance from peers and to achieve autonomy (Shulman et al., 2016).

In recent years there has been a rise in punitive discipline for low-level behaviours such as making jokes, uniform breaches and laughing (Okonofua et al., 2016). The issue of conformity to school rules is nationally published, with children being excluded from schools in England for reasons such as: not wearing the right uniform or wearing too much makeup (Horton, 2017). Munn and Lloyd (2005) express that children behave differently in different classrooms and that a critical influence on their behaviour is the teachers own self-concept and sense of self-esteem, they can label children based on reputation.

The American Psychological Association (APA, 2008) reviewed the evidence on the effectiveness of zero-tolerance behaviour policies and found they negatively impact:

1. The relationship between schools and the criminal justice system
2. Child development (adolescents who receive severe consequences due to poor judgement even though their brains are still developmentally immature)

The House of Commons (2018, p. 13) view is that ‘it would be reasonable for schools to take a zero-tolerance approach to drugs or weapons. A school culture which is intolerant of minor infractions of school policies, haircuts or uniforms, will create an environment where pupils are punished needlessly where there should be a degree of flexibility and a degree of discretion’. This correlates with the views found in research that adolescents may react to discipline for minor infractions by re-establishing their autonomy through defiant behaviour (Brehm, 1966; Bryan et al., 2016, Okonofua et al., 2016). Munn and Lloyd (2005) advocated active pupil participation in school and classroom decision making about rules, rewards and sanctions. This would not necessarily eradicate disruption, but it could minimise it and enhance pupil-teacher relationships. The remaining sections of chapter 1 focus on key issues that impact on children’s ability to participate and learn in schools.

2.9.8. Class sizes

In 2017, English primary school class sizes were deemed to be the third-largest among the 37 Organisation for Economic Co-operation and Development (OECD) countries (2019), and secondary education classes the 14th largest. They remark that England is unique in that numbers per class decrease between primary and secondary (averaging 27 at primary and 23 at lower secondary). It is widely accepted that classroom engagement decreases in larger classes and this is particularly evident for lower attaining children at secondary school age (Smith and Glass, 1990; Blatchford et al., 2011; Sanders et al., 1997). An alternative view was previously given by Sanders et al. (1997) that it is not the class size that makes the difference to learning but the quality of the teachers. The recently held view is that teachers who have large class sizes cannot be expected to effectively and consistently provide individualised educational support (Webster and Blatchford, 2017). Hart et al. (2011) reported that children with attention deficit hyperactivity disorder (ADHD) would be more 'on task' during small-group instruction than both whole-class teaching and independent activities. They suggest that for best results, small class sizes should be introduced immediately following school entry (Blatchford et al., 2003) as these enable teachers to individualise teaching and to differentiate the curriculum (Graue et al., 2008). However, Blatchford et al. (2011) note that what is considered to be a 'small class size' is of ongoing debate due to a lack of research in this area.

2.10. Enablers to mainstream schooling

Cosma and Soni (2019) argue that children feel their educational provision is not appropriate for their needs, and that pressures are too high and levels of support are too low. These findings have been reported in other research, identifying that the reason they have negative behavioural responses is justified because teachers don't meet their learning needs even when they are asking for help (Nind et al., 2012). Michael and Frederickson (2013) and Tellis-James and Fox (2016) carried out research with children

with SEMH needs who, when asked, said they needed a personalised curriculum that took into account their strengths, and emotional and behavioural difficulties.

The Code (DfE, 2015a) shares a definition of disability that draws upon the Equality Act (2010). This explains that children have a disability if they present with '... a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities' (p. 135). This definition provides a relatively low threshold for disability and includes more children than many realise. 'Long-term' is defined as 'a year or more', and 'substantial' is defined as 'more than minor or trivial'. The following needs are automatically treated as a disability under the Equality Act (2010). The DfE (2014c) guidance, 'The Equality Act 2010 and schools', is explicit that the overriding principle of the equality legislation is that schools may be required to treat those with disabilities differently by making reasonable adjustments. The duty to make reasonable adjustments applies only to children with disabilities. For schools, the duty is summarised as follows:

- Where something a school does places a disabled pupil at a disadvantage compared to other pupils, then the school must take reasonable steps to try and avoid that disadvantage.
- Schools will be expected to provide an auxiliary aid or service for a disabled pupil when it would be reasonable to do so and if such an aid would alleviate any substantial disadvantage that the pupil faces in comparison to non-disabled pupils (DfE, 2014c).

2.10.1. Relationships

Positive teacher-student relationships are believed to have an energising function that supports positive academic-related outcomes (Furrer et al., 2014). The higher the quality of this relationship, the more likely the child is to participate in and enjoy school (Martin and Collie, 2019). Ruzek et al. (2016) highlighted that where classrooms had emotionally supportive teachers, the children experienced more autonomy, resulting in positive outcomes. This correlates with research that has identified that positive relationships with staff contributes to a more positive schooling experience for children (Sellman, 2009; Nind et al., 2012; Jalali and Morgan, 2018). Meehan et al. (2003) and Martin and Dowson (2009) agree, adding that positive teacher-pupil relationships are a protective factor which can help children manage in school despite their difficulties.

Previous research identifies how children feel negatively perceived by teachers due to their past behaviours and experiences within education (Nind et al., 2012; Michael and Fredrickson, 2013; Sheffield and Morgan, 2017), and how children believe teachers focus on the negative aspects of their behaviour (O'Connor et al., 2011). Negative teacher-student relationships are considered to have a cumulative and chronic effects on children's outcomes (Wentzel, 2009; Hughes et al., 2012). Cosma and Soni (2019) agree that past negative relationships with teachers are a key contributor to behavioural responses and subsequent school exclusion. NICE (2017) advocate training and development to ensure teachers have the knowledge, understanding and skills to build successful relationships with children and to deliver the curriculum effectively. This should include activities to support children in developing social and emotional skills and wellbeing to prevent behavioural difficulties in all areas of school life.

2.10.2. No contact policies

Research on the importance of touch for children dates back to the 1940s, with studies by Spitz (1945, 1946, 1951) and Harlow (1959, 1963) highlighting the importance of touch and physical proximity for healthy physical, mental and social development. The need for children to have physical contact to develop and feel good continues to be documented (Andersen, 2008; Underdown et al., 2010, 2013; Johansson, 2013). The benefits of touch are: reduced stress and a positive impact on well-being (Field, 2002). The DfE (2019, p. 29) 'Keeping children safe in education' guidance states that 'the adoption of a 'no contact' policy at a school or college can leave staff unable to support and protect their pupils and students fully. It encourages headteachers, principals, governing bodies and proprietors to adopt sensible policies, which allow and support their staff to make appropriate physical contact'. This guidance supports the use of physical contact with children where there is a need and a want. As Piper and Smith (2003) and McWilliam and Jones (2005) suggest, consideration needs to be given to who may touch the children and when and how it should take place. Physically touching children in education continues to be a difficult subject and one which requires respect for the child's body (Ohman, 2016). The reasons why touch does not happen is due primarily to the fear of being vulnerable to suspicion of abuse and paedophilia (Munk et al., 2013). This is the case for both men and women working with children, who worry it will create suspicion and distrust (Piper et al., 2012). In summary, the literature over the last eighty years states that what is harmful to children is not too much but too little touch (Piper et al., 2012).

2.10.3. Noise

Noise has been defined as ‘unpleasant sounds which distract the human being physically and physiologically’ (Melnick, 1979, p. 72). Sensory processing is the way the central and peripheral nervous systems manage incoming sensory information from the sensory organs, namely visual, auditory, tactile, taste, smell, proprioception and vestibular (Fernandez-Andres et al., 2015, p. 203). Sensory processing difficulties have been reported as highly prevalent in the case of children with autism spectrum disorders (ASD) (Baranek et al., 2006; Costa and Lampreia, 2012) and children with other aspects of neurodiversity (Cheung and Sui, 2009; O’Brien et al., 2009; Wiggins et al., 2009). For children with ASD, 70% are believed to have hypersensitivity to auditory stimuli (Bromley et al., 2004). This can include unexpected sounds such as fire alarms, toilets flushing, children’s voices, clapping and acoustics (Dickie et al., 2009). It has been shown that noise can have a negative effect on health and physiological and psychological outcomes (Atmaca et al., 2005). Suter (1989) shared that the physiological effects can interfere with performance in tasks, startle response, increase muscle tension and increase aggressive behaviour. Atmaca et al. (2005) add that psychological effects include irritation, anxiety, anger, restlessness and lack of concentration. When children are distracted by noise, it decreases attention (Shield et al., 2010). Noise can be felt from teachers, the classroom environment, external to the school, heating, ventilation and air conditioning (Woolner and Hall, 2010). The literature on the detrimental effects of noise on children’s mental health shows that for those with sensitivities, there needs to be consideration of noise buffering in classrooms (Kanakri et al., 2017).

2.10.4. Belonging

Osterman (2000) carried out a comprehensive review of school connection and found that having a sense of belonging is associated with a healthy child and adolescent development. To achieve this, children need to feel related to the school environment and to have positive attitudes towards classwork, teachers and their peers. This view has recently been supported by Nind et al. (2012) and Tellis-James and Fox (2016), who shared that positive educational experiences are achieved through children securing a sense of belonging, through in-school and extra-curricular activities (Bouchard and Berg, 2017). Mann and Lloyd (2005) propose that routine practices in school can promote, or not, a sense of belonging through how interested teachers are in children’s lives and the mutual respect between them and children. The impact of not being connected is associated with negative behaviours in the classroom, low engagement in lessons and lower achievement (Osterman, 2000). A sense of belonging is more likely in primary school but less evident for some children in secondary education, who felt a lack of connectedness, due to feelings of inadequacy and academic failure (Jalali and Morgan, 2018).

2.11. Access to health services

Multi-agency working has been at the core of child mental health policy in recent years, with the aim of providing comprehensive and seamless services for children, young people and their families, particularly those with complex difficulties (O’Reilly et al., 2013, p. 7). The Department of Health and NHS England’s Task Force on Children and Young People’s Mental Health and Wellbeing recognised there was fragmentation and a ‘lack of cohesion’ leading to children falling between the gaps in service provision (2015a, p. 3). The Future in Mind report, recommended a ‘whole system’ approach and ‘coordination of assessment and planning around the individual child, involving all relevant services, facilitated by information sharing and a lead professional or key worker’ (Department of Health and NHS England 2015b, p. 57).

2.11.1. Definitions and prevalence of mental health

The World Health Organisation (2018b) defines mental health as ‘a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to the community’. Within the Code (DfE, 2015a), social-emotional and mental health (SEMH) difficulties are one of the four broad areas of need. The Mental Health Taskforce (2016) advises that certain groups of children are more susceptible to develop mental health difficulties, including those who are looked after, previously looked after, have disabilities, have long term health needs or are in the criminal justice system. NHS digital (2018) identifies that mental health difficulties develop early and that between the ages of five and 15, one in nine children will have a diagnosable mental health need. This is an increase from the 1 in 10 figure reported by NHS England in 2017. It is also understood that half of all mental health challenges become established by the time the child is 14 (Kessler et al., 2005).

Martin-Denham and Watts (2019) remark that difficulties with mental health can vary in intensity, duration and the impact they have on the child, their needs and their behaviours, and the extent to which they impact on their ability to participate and learn in school. NHS (2015a) report that mental health needs can vary from short spells of depression to severe and persistent conditions that can disrupt, isolate and frighten those who are experiencing them. They are likely to coexist with other health and learning needs. Furthermore, mental health needs may lapse, return or remain throughout childhood into adulthood if not addressed early, increasing the likelihood of school exclusion, school refusal, teenage pregnancy and criminality (Beecham, 2014).

2.11.2. Health services

In 2017, the NHS set out an ambition to support clinical commissioning groups (CCGs) to work with partners to build effective, evidence-based, outcome focussed child and adolescent mental health services (CAMHS). NHS England’s guidance to CCGs was that they are expected to commission complementary provision for children who do not meet the minimum thresholds for specialist CAMHS support (Children’s Commissioner Office, 2018b). In Sunderland, children who do not reach the minimum threshold of Tier 1 (see below) are referred to partner organisations and/or voluntary organisations (Sunderland CCG, 2019).

Tier 1: services for children, young people and their families with mild, early-stage problems delivered by non-specialist primary care workers, including teachers, school nurses and health visitors

Tier 2: services for children, young people and their families with moderate levels of mental health need to be delivered by specialised Primary Mental Health Workers

Tier 3: services for children, young people and their families with complex, severe or persistent levels of mental health provided by specialist multidisciplinary teams

Tier 4: services for children, young people and families with highly complex, severe or persistent levels of mental health need often delivered in a specialised day and in-patient settings

In addition to this and, particular to Sunderland, children who are identified as having ‘special circumstances’, that is, who belong to an ‘at-risk group’, who are more likely to develop mental health problems will not be seen by CAMHS but are instead referred to CYPS. Special circumstances include those who have:

1. Learning disabilities
2. Been looked after or accommodated, including those who have been adopted
3. Been neglected or abused, or are part of a child protection plan
4. Learning or physical disability
5. A chronic, enduring or life-limiting illness
6. Substance misuse issues
7. Risk of, or have been involved in offending
8. A status of homeless or who are from families who are homeless
9. Parents who have problems including domestic violence, illness, dependency or addiction
10. Been placed out of the area
11. Been placed in a secure placement
12. Parents in prison
13. Identified as being a minority ethnic or minority cultural background including travellers
14. Not been involved in education, employment or training.

(Sunderland CCG, 2019)

This special circumstances list would mean that many children are unable to be assessed by CAMHS and would then join the waiting list for Children and Young People’s Services (CYPS). This is a single service that is provided for children who are presenting with mental health difficulties. In most NHS Trusts, the age range for referrals is 0-18 years. In Sunderland, they provide tier 2 targeted services for children in the above special circumstances and Tier 3 mental health assessment and intervention.

In 2018, a report by The National Association of Headteachers described how 45% of school leaders encountered difficulties commissioning mental health support for children in their care. They claimed that not knowing what support was available was a barrier to providing effective mental health support. A lack of

information available to service users is widely acknowledged in research, in particular not knowing where a service is, the pathways, or how to make an appointment to seek mental health support (Boyd et al., 2011; McCann and Lubman, 2012). Caregivers have also cited not knowing where to go as a barrier to seeking support for their children (Iskra et al., 2015). Anderson et al. (2017) believe this is a common issue due to services not being well publicised. Hence, caregivers have to ask around to find where to request support. This is a particular issue for those with language barriers (Williams et al., 2013).

Crenna-Jennings and Hutchinson (2018) examined how many children were referred to mental health support and how many weren’t accepted. Their findings were:

- Over the last five years, the number of referrals to CAMHS has increased by 26%
- Approximately 55,800 children were not deemed appropriate for support
- Self-harm did not always trigger specialist services
- The average waiting time to be seen in 2017-18 was 34 days for assessment and 60 days for treatment

It has been identified by Bone et al. (2015) that there has been investment on and growth of CAMHS services in recent years but that the service varies across local areas and it is failing to fully meet demands (Rao et al., 2010). Multiple studies have identified that long wait times are the most commonly cited barrier to engaging with mental health services from service users (Golding, 2010; Vohra et al., 2014; Iskra et al., 2015; Anderson et al., 2017). There is also a suggestion that adolescents find long wait times frustrating, making them feel their issues are not considered severe enough to be heard. This deters some from persevering with gaining an appointment (McCann and Lubman, 2012). Overall, the evidence suggests that long waiting lists have a negative impact on family engagement with services for mental health support as there is a link between delays

in appointments being scheduled, the length of time between referral and appointment, and the likelihood of the service user attending the initial consultation (Gallucci et al., 2005; Westin et al., 2014).

A further barrier to ensuring children attend mental health appointments is complex administration procedures, such as having to make numerous phone calls to find a clinician, to explain why their child needs to be seen and to explain the treatment history (Cohen et al., 2012; Radovic et al., 2014). An additional frustration for caregivers is having to make multiple referrals to get to the right service, only to be referred to another service and then joining another long waiting list (Iskra et al., 2015). Reid et al. (2011) highlight that caregivers have to find different health professionals for a range of issues. Historically, it has been reported that to overcome administrative barriers to CAMHS, you have to be demanding, persistent, vocal, pushy, complain and write letters (Boydell et al., 2006). Barwick et al. (2013) suggest that providing community walk-in clinics has been shown to improve access to care for those disengaged by complicated referral procedures and long waiting lists. Service users were seen quicker and subsequently needed fewer appointments. Phone-based interventions and video conferencing have been shown to increase intake and uptake of future appointments (Calvaleri et al., 2010; Boydell et al., 2014). Similar positive results have been found in mental health services through online forums and advertising in places where services can be seen by children (Anderson et al., 2017).

2.11.3. Funding for health services for children

The NHS reports that funding has fared better for the organisation compared to other public services, but funding per person will reduce in 2018/19 and 2019/20 (2019a) as capital investment has been limited over recent years (Office for Budget Responsibility, 2016). NHS funding, like other public services, is reliant on a well-performing UK economy. Due to the

recession in 2008, NHS funding growth has been slower than historical trends (IFS, 2016). The Children's Commissioner Office (2018a) states that health spending in England is poorly measured and that many children's health services tend not to be for acute health problems, so are more vulnerable to cuts.

2.12. School exclusion

'Fixed-period' and 'permanent' exclusions were introduced in 1986 in the UK as a last resort to remove a child from school when they were deemed to be persistently or severely deviating from the school's behaviour policy (Education Act, 1986). The 2011 Education Act is the main statute that sets out duties when excluding a child. Independent Provider of Special Education Advice IPSEA (2017) confirms that there are two lawful types of exclusion; permanent and fixed-period. Only the headteacher of a school (or the teacher in charge of a pupil referral unit or the principal of an academy) can exclude a child. The legal stance is that a child is either in school full time or excluded, so informal or unofficial exclusions, such as sending a child home for the afternoon following an incident are unlawful (Martin-Denham and Watts, 2019). They add that if a caregiver is asked to keep their child off school, it is an exclusion, whether it is leaving early, at lunchtime or being part-time. All exclusions must be recorded in school and reported to the Local Authority (LA).

Unlike other nations within the UK, permanent exclusions in England have risen significantly in recent years (Power and Taylor, 2018). Data presented in Table 1 shows that England had the highest rates of both fixed and permanent exclusions in the UK, with thousands excluded between 2015/16 compared to only five in Scotland.

Table 1: Rates of fixed-period and permanent exclusion across the UK in 2015/16

Nation	School Population	Fixed Period Exclusions	%	Permanent Exclusions	%
England	8,559,540	339,360	4.0	6,685	0.08
Scotland	680,007	18,430	2.7	5	0.02
Wales	466,555	15,051	3.2	109	0.000007
Northern Ireland	339,785	4,147	1.2	19	0.0006

It has been suggested by Parsons (2005) that the reason for markedly different profiles between the countries is due to differing reform agendas of the four nations in the UK and in particular the negative consequences of education policies in England. The ‘marketisation’ of education in England has created pressures for schools to exclude children who will negatively affect performance data and league tables (Booth et al., 1997). The introduction of academy schools, which remain outside of the Local Authority (LA) system, has resulted in academies having a lower number of children with SEN compared to those forced to convert due to low attainment (Norwich, 2017). This view has been supported by Gazeley (2010), who reported findings in one LA that schools have difficulty reconciling the need to meet academic targets and to do well in Ofsted inspections with inclusive approaches to managing behaviour. Academies and free schools, which are growing in number, are more likely to exclude than any other type of school, as they operate outside of LA control (West and Bailey, 2013; Gorard, 2014).

2.13. Internal exclusion

The Department for Children Schools and Families (DCSF) (2008) signalled the way for ‘internal exclusion’ or ‘remove rooms’ in their now archived guidance to schools on good practice. These are described as an internal process within the school to remove the pupil from class, not from the school site, for disciplinary reasons. The guidance goes on to clarify that the child should receive an appropriately supervised education for the shortest period possible and be allowed to reflect on their behaviour. Ofsted (2018) confirm that schools can place children in isolation for a limited period; this should be made clear in

behaviour policies and be lawful, reasonable and proportionate. The key issue in England is that the Department of Education appears to be delegating ethical responsibility for its use to the schools themselves and there is no clarification of the meaning of what is meant by ‘for a limited period’ (DfE, 2016). It is also of concern that it is for schools to decide how long a child should be kept in isolation and for staff to determine what they may and may not do during the time they are in there. This ‘advice’ gives schools free rein to do as they see fit with no accountability or monitoring of the frequency or impact on the child’s holistic development.

Barker et al. (2010) suggested that in the UK the introduction of school based-internal exclusion, now commonly known as ‘isolation’ was a response to political pressure on schools to raise standards, reduce school exclusions and to remove ‘undesirable’ children from public spaces during school hours. The House of Commons (2018) shared their evidence that children had been put in isolation in mainstream school for large parts of the academic year; some for behaviour and some for self-protection from bullying. The children’s responses in this evidence included ‘they would give you a book to copy from; there would be no real learning’. Furthermore, one of the most important social factors predicting healthy behaviours and development in adolescents is having peers (Umberson et al., 2010). There is evidence that isolating children may increase risks of ill health, substance misuse, self- medication, anxiety and loneliness (Hall-Lande et al., 2007; Osgood et al., 2014) and anti-social activities (Kreager, 2004). These findings are at odds with the DfE requirement (2016) that schools must ensure the health and welfare of the child during their time in isolation.

The option to isolate children has led to schools having less inclusive approaches to behaviour management. With local authorities having increasing numbers of academies beyond their control, they are powerless to intervene (Gazeley 2010; West and Bailey, 2013; Gorard, 2014). Power and Taylor (2018) theorise that if definitions of school exclusion were to be expanded to include the range of practices that schools use to remove children from the mainstream classroom, while keeping them on the school roll, the rate of exclusion would be higher than official data. Currently, this casts doubt on how useful official exclusion data is in indicating how inclusive a school is.

The Human Rights Act 1998 provides the fundamental rights and freedoms that apply to everyone in Britain. They incorporate the rights from the European Convention on Human Rights (ECHR) into domestic law (Ofsted, 2018). The following rights are relevant to the use of isolation and restraint:

- Article 3- Prohibition of torture: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
- Article 5- Everyone has the right to liberty and security of person
- Article 8 - The right to respect for private and family life
- Article 14 - Prohibition of discrimination

(Council of Europe, ud)

A report by the Centre for the Advancement of Positive Behaviour Support (CAPBS) (2015) suggests that the use of seclusion in schools could breach Article 5 of the Human Rights Act:

- Outside of an emergency situation where staff need to exercise the duty of care to prevent harm, seclusion is not acceptable and is likely to be a breach of Human Rights and criminal law, i.e. false imprisonment

- Any emergency use of seclusion should trigger a review
- Any Deprivation of liberty needs legal authorisation (outside of lawful detainment)
- Seclusion is not therapeutic and is likely to cause psychological harm
- Schools should issue clear guidance to staff on the use of isolation and punitive responses to children with special needs, and review blanket policies
- ‘Time out’ is a psychological intervention. It should not be used as a matter of course. Staff should be clear about the difference between ‘time out’ and the use of ‘time away’ as a proactive strategy.

The attitude of the Department of Education is in stark contrast to the guidelines issued by the Department of Health (2014) regarding the use of restrictive practices: restrictive practices should never be used as punishment. The Mental Health Code of Practice states unequivocally that ‘seclusion can be a traumatic experience for any individual but can have particularly adverse implications on the emotional development of a child or young person’ (Centre for the Advancement of Positive Behaviour Support (CAPBS, 2015). Yet, here we have children being systematically subject to seclusion. This correlates with historical research by Miller (1986), one of the few researchers to have examined the use of exclusion on children by drawing images of the experience. Their descriptions conveyed punishment, fear and abandonment. The Department of Health (2014, para 87) defines seclusion as ‘the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving’. This looks remarkably similar to the use of isolation within English schools.

2.14. Restraint

The use of 'restraint' in English schools is set out in the document, Use of Reasonable Force: Advice for headteachers, staff and governors (DfE, 2013), which clarifies that 'reasonable force' cannot be used as a punishment. The Keeping children safe in education guidance document (DfE, 2019, p. 29) clarifies:

'The term 'reasonable force' covers the broad range of actions used by staff that involve a degree of physical contact to control or restrain children. This can range from guiding a child to safety by the arm to more extreme circumstances such as breaking up a fight or where a young person needs to be restrained to prevent violence or injury. 'Reasonable' in these circumstances means 'using no more force than is needed'. The use of force may involve either passive physical contact, such as standing between pupils or blocking a pupil's path, or active physical contact such as leading a pupil by the arm out of the classroom'.

However, recent research has found that in some schools, physical restraint had been used as a form of punishment (McCluskey et al., 2015). 'Restraint means to hold back physically or to bring a pupil under control, and is typically used in more extreme circumstances, for example when two pupils are fighting and refuse to separate without physical intervention' (DfE, 2013, p 4). Restraint is permissible in education to keep children or staff safe; there is no legal duty to record or report incidents when restraint has been used (Ofsted, 2018). They add that the expectation is that adults must be skilled and confident in finding the best way to keep children safe in ways that promote their rights, respect their dignity and equip them for the future. Isolation and seclusion in school are classified as a restriction on children's lives, and include locking doors, leaving a child alone and time out. The Equality and Human Rights Commission (2020) has launched an inquiry into how schools in England and Wales are monitoring and recording the use of restraint and restrictive practices. This has arisen due to concerns about the lack of data available on these approaches.

The Physical Control in Care Medical Panel (2008, as cited in DfE, 2013, p.6) outlined how the following restraint techniques pose an 'unacceptable risk when used on children and young people', they are:

- The 'seated double embrace' where two members of staff force a child into a sitting position and lean them forward, while a third member of staff monitors breathing
- The 'double basket-hold' which involves a member of staff holding a child's arms across their chest and;
- The 'nose distraction technique' which involves a sharp upward jab under the child's nose.

The DfE guidance (2019, p. 29) is clear that in response to risks presented by children with SEN, disabilities or medical conditions that:

'Schools and colleges should in considering the risks carefully recognise the additional vulnerability of these groups. They should also consider their duties under the Equality Act 2010 in relation to making reasonable adjustments, non-discrimination and their Public Sector Equality Duty.⁴¹ By planning positive and proactive behaviour support, for instance through drawing up individual behaviour plans for more vulnerable children and agreeing on them with parents and carers, schools and colleges can reduce the occurrence of challenging behaviour and the need to use reasonable force'.

A Freedom of Information request in 2017 by the BBC to local authorities in England, Scotland and Wales revealed that there were 13,000 physical restraints in the past three years, resulting in 731 injuries. However, the majority of LAs did not respond with figures, arguing that they did not keep such data (Harte, 2017). This suggests that the use of restraint, including harmful restraint, is much more widespread in British schools. For a child facing a potential or actual restraint, their body becomes hyper-aroused because they sense danger and perceive it as abuse. As they struggle, there is potential for injury and death through resisting the restraint or the sheer force of those carrying out the restraint (Mohr and Mohr, 2000).

Ofsted (2018, p.3) clarify that staff should work positively and confidently with children and find the least intrusive way possible to support, empower and keep children safe. This should include:

- building relationships of trust and understanding
- understanding triggers and finding solutions
- if incidents occur, defusing the situation and/or distracting the child wherever possible

All restrictive practices within health and social care are subject to clear ethical principles and guidelines, found in Positive and Proactive Care: reducing the need for restrictive interventions (DoH, 2014) and the Mental Health Code of Practice (DoH, 2015). Restrictive practices are highly contentious in health and social care settings and are circumscribed by strict ethical guidelines following the Winterbourne Scandal (2011). The spectrum of restriction ranges from isolation and seclusion to long term segregation, from chemical, mechanical and physical restraint. These latter techniques are used to control extreme and out of control behaviour of individuals. However, in practice, as at Winterbourne, they can be used as facilitating tools for an aggressive and uncontrolled regime based on cruel and malevolent intent. The Department of Health guidance for the use of restrictive

interventions (2014) provides six fundamental principles:

- Compliance with the relevant rights in the European Convention on Human Rights at all times
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced
- Involvement and participation of people with care and support needs, their families, carers and advocates is essential, wherever practicable, and subject to the person's wishes and confidentiality obligations
- People must be treated with compassion, dignity and kindness
- Health and social care services must support people to balance safety from harm and freedom of choice
- Positive relationships between the people who deliver services and the people they support must be protected and preserved

Within health, there is a requirement for all services who use restrictive interventions to have in place 'restrictive intervention reduction programmes' to use less detrimental alternatives to restraint (DoH, 2014). They also provide post-incident reviews, which are a recommendation of this research

The American Psychiatric Association (2003) suggest alternatives to the restraint of children, to enable trying to determine the underlying message conveyed by the child's behaviour(s), so that the cause can be identified and the child supported. This is also advocated within the DfE (2015a) Code. Other recognised strategies are: positive reinforcement by spending more time with the child, with a focus on good behaviours, rather than negative reinforcement of secluding them in the hope this will modify behaviour. This approach saw a 97% reduction in seclusion episodes in two months (Irwin, 1987). Some training courses promote person-centred approaches to crisis management to negate the

need for physical intervention, such as studio 3's three-day 'managing challenging behaviour' programme, accredited by British Institute of Learning Disabilities (BILD).

2.15. Outdoor learning and physical activity

Internationally, an all-encompassing definition of outdoor education is scarcely possible due to the range of different meanings, understandings and practices in research, countries and cultures (Allison, 2016). Waite et al. (2015) examined the context of regular outdoor education within the school curriculum, comparing Danish and English approaches, and focusing on aims, pedagogy, content, outcomes and barriers. They found that both methods seem to support children in social, academic, physiological and psychological wellbeing. This was echoed in a systematic review by Becker et al. (2017), who shared that regular curriculum-based outdoor learning advances physical and psychological learning, and social dimensions. The barriers to outdoor learning include: cost of transportation, travel time, extra teacher and qualifications (Waite et al., 2015).

The Good Childhood Report (2018, p.40) says that over a third of children (38%) said they had been physically active on five or more days in the past week. It adds that children with low life satisfaction and those with more serious emotional and behavioural difficulties and depressive symptoms were less likely to be physically active than other children. In research shared by Fix et al. (2019), teachers were convinced of the positive effect of physical activity and sport for children's social development. This supports other findings by Bailey (2005), and Donaldson and Ronan (2006), who also found the benefit of sport on both social and emotional development. Though it needs to be noted that for some children, sport can negatively impact on their self-esteem if they perceive they have lower-level skills than their peers (Fraser-Thomas and Côté, 2009). Overall, the literature suggests that sports may be useful for at-risk children when there is a positive peer group climate and good relationships with teachers (Sandford, 2006; Bruner et al., 2011).

The next section describes the methodological approaches employed to answer the following research aims and objectives:

Research aim

To investigate the factors that impact upon social and emotional wellbeing of children and young people from 3-16 years in Sunderland Local Authority, which may lead to exclusion from school

Research objectives

To elicit the perceptions and experiences of excluded children, their caregivers, and professionals, of the barriers and enablers to mainstream schooling

- To determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream school.
- To evaluate the effectiveness of national policy in supporting children to remain in mainstream school

To produce a report, with supporting evidence, to inform provision planning and training for education professionals within the local area of Sunderland

3. Methods

3. Methods

The method section presents the approaches adopted and procedures used when carrying out the research. Overall, the section will share the researcher's philosophical perspective, the data collection methods used, participant demographics and how they were recruited, data analysis and research ethics.

3.1. Paradigm

The term paradigm is used to describe a researcher's philosophical perspective when carrying out research (Guba and Lincoln, 1986; Mackenzie and Knipe, 2006). Four main components make up a paradigm; epistemology, ontology, methodology and axiology. While detailed descriptions of these components are beyond the scope of this report, overall, they link the research philosophy to practice (Newby, 2014). When carrying out research that involves a level of interpretation, it is essential to disclose the researcher's underlying philosophical perspective as it directly influences the data collection methods, analysis and any final interpretation (Kivunja and Kuini, 2017).

The objectives of the research were to elicit and determine the enablers and barriers to mainstream schooling from the perspective of children excluded from school, their caregivers, headteachers and SENCOs. Therefore, an interpretive perspective was chosen for this research. This is summarised by the assumption that reality differs from person to person and is consequently subjective (Guba and Lincoln, 1994). Interpretivism predominantly uses qualitative data collection methods (Silverman, 2000; Willis, 2007; Nind and Todd, 2011), which are shown below.

3.2. Methodology

As the aim of the research was to provide a detailed examination of participants' personal lived experiences, the qualitative approach chosen was interpretative phenomenological analysis (IPA) (Smith and Osborn, 2015). The

assumptions of IPA are that individuals make choices but are limited by their present conditions; this is known as situated freedom (Webb and Welsh, 2019). The research aimed to understand the participants' experiences and to develop a phenomenological interpretation as a whole, characterised by:

- An emphasis on the phenomenon
- A focus on the philosophical supposition;
- The use of interviews to collect data;
- Typically qualitative data analysis
- The culmination of a rich description of the phenomenon (Cresswell and Cresswell, 2013).

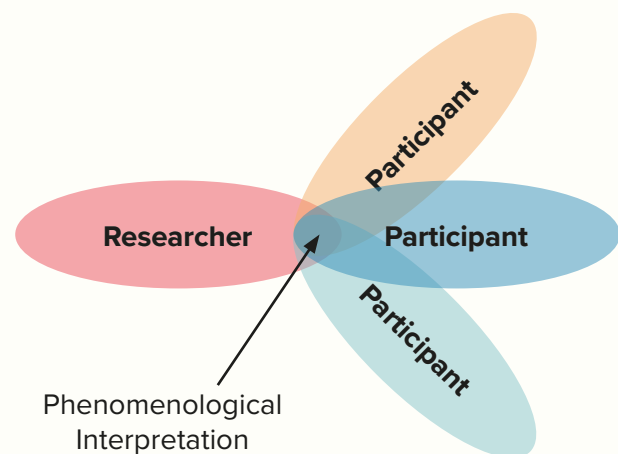


Figure 4: Phenomenological interpretation

Figure 5 below presents the steps that informed the research procedure for this study.

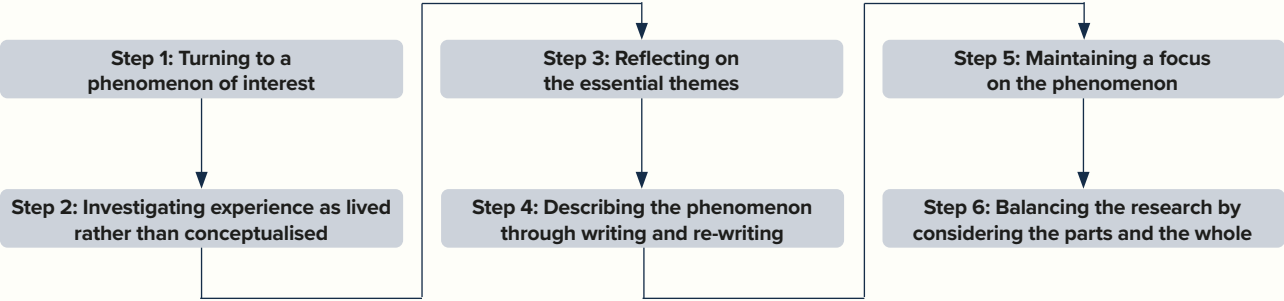


Figure 5: Phenomenological inquiry steps (adapted from van Manen, 1997)

3.3. Methods

The data collection methods used for this research were a combination of one-to-one and group semi-structured interviews. Semi-structured interviews use set questions, but also use an adaptable style to allow for relevant experiences or views to be explored (O’Leary, 2004). When interviewing children and young people, the term ‘conversation’ was used instead of ‘interview’. All interviews were recorded using a Dictaphone and transcribed verbatim, excluding any identifiable information.

3.4. Participants

There were 174 participants interviewed. The sample included 55 children, 41 of their caregivers, and 69 education professionals including head teachers from nursery to secondary age phase and 14 Special Educational Needs Co-ordinators (SENCOs) and class teachers. Nine health and support professionals were interviewed and there were an additional three advisory groups consisting of 12 children, five professionals from health/support services and five education professionals.

Table 2: Participant sample and subgroups

Group	Number	Group	Number
Children	55	Professionals	78
KS1	20	Nursery headteachers	4
KS2/3	15	Primary headteachers	28
KS4	20	Secondary headteachers	9
Caregivers	41	Specialist headteachers	4
KS1	4	ARP/AP headteachers	10
KS2-3	16	SENCO	14
KS4	21	Health and support professionals	9

3.5. Participant recruitment

Participants were recruited using purposeful sampling, which is described as the identification and ‘selection of individuals that are experienced in or are knowledgeable of the subject of interest’ (Cresswell and Plano Clark, 2011, p173). The principal investigator liaised with gatekeepers, who could brief school staff on the purpose of the research and in turn, relay this to the child and adult participants. Letters were sent home to caregivers to explain the study, to provide information sheets containing details about ethical considerations such as their right to withdraw and confidentiality, were sent home to caregivers to explain the study. These were followed up with telephone calls from the school or the research director. All children and caregivers in both provisions were given the opportunity to take part. They were told of the need for voluntary consent and their right to withdraw within six months of the interview taking place (British Educational Research Association, 2019).

Children were recruited from alternative provisions in Sunderland following gatekeepers’ permission. The children ranged in age from 5-16 and all apart from key stage one had been permanently excluded. Many had also received fixed-period exclusions. Two key stage one children had permanent exclusions and the remaining children were identified as being at risk of school exclusion by their school. None of the children had an education, health and care (EHC) plan and no caregiver reported their child as being on the SEN register. However, at the

time of the research, with children in alternative provision, some were on the SEN register, with a diagnosis of ASD, ADHD and SEMH.

Caregivers of children were recruited from the same provisions as children. Headteachers and SENCOs were invited to participate by the funder and the University Research team. Controls were put into place to recruit staff from schools with high and low exclusion rates, and a range of Ofsted rated schools were included as part of the sample. Where schools did not consent to take part in the research, replacement schools were sought and recruited.

3.6. Ethical procedures and compliance

The project was submitted to and approved by the University of Sunderland Ethics Committee in March 2018. The following section outlines the process that was adhered to when gaining voluntary and informed consent in accordance with the BERA (2018) and the five principles from the NSPCC (2018).

3.6.1. Caregivers' voluntary and informed consent

BERA (2018) clarifies that it is fundamental research practice to obtain voluntary informed consent prior to any research.

1. The information sheet and consent form was shared with the caregiver by the gatekeeper or member of the school team alongside a verbal explanation of the purposes of the research and to explain that participation was voluntary. This was to ensure that they understood the purpose of the project. At this stage, the caregivers gave consent to be interviewed and for their child to participate. For early years and key stage one, the research team visited the provision to meet caregivers to have casual conversations and to build trust (Gibson, 2012).
2. At the interview, consent was checked both in terms of signed/verbal consent prior to any recording on the Dictaphone.
3. At the end of the interview, the caregivers were asked if they would consent to their children taking part. This included sharing the questions the children would be asked with the caregivers, so they could make an informed decision. They also had the option of being present for the conversation, making them feel more comfortable with the researcher and strengthening cooperation (Greene and Hill, 2005). For any children who were designated as 'looked after', consent was gained from their social worker and foster carer, as appropriate.
4. All of the caregivers who were interviewed were invited to the University of Sunderland to be on the advisory group; none of the caregivers were able to take part.

3.6.2. Children's voluntary and informed consent

The challenge in this research was ensuring the children and young people had accessible (age and developmentally appropriate) information to make an informed choice about whether or not to take part. The school staff shared the research overview with all children and to gain initial consent. Because participation was not based on a one-off decision, consent was also obtained prior to the conversation with the researcher (NSPCC, 2018). On the day of the conversation, a comic strip was used to remind the children of the research (and to check they were fully informed) and to provide an opportunity to ask questions. Information that was reiterated included: how their views were confidential; that the conversation would last 20 - 30 minutes; how the children can say 'stop' at any time; and that they did not have to answer any questions they found difficult to talk about. The informed consent process for the children was as follows:

1. Once gatekeeper and caregiver consent were received, the school staff then explained the purpose of the research to the children. A list of those who wished to take part was created and kept within the school, so the participants were self-selected. If the caregivers consented to their child taking part but the child did not, the child did not take part in the research.
2. The venue was agreed.
3. On the day of the interviews, the researcher explained the purpose of the research to the child and gained formal consent using a comic strip and emoji faces with Yes/No next to them. This was to allow the children to indicate consent by circling their choice (the words were important should they not be able to identify with emotions on emojis). All children were given the opportunity to ask questions about the research and the process and structure of the conversation. Any children who did not consent (to either the caregiver or researcher) did not take part. This was important as it gave the children

time to reflect on whether or not they wanted to take part between being told about the research from the gatekeeper and the day of the conversations. For the children in early years and key stage one, the school team, represented by a safe and familiar adult, led the conversations with the children.

4. The date and time of interviews were flexible and were scheduled so that children would not miss favourite lessons or activities. Gibson (2012) suggests that the researcher engages in activities with children to promote the enjoyment of the process and create a partnership that builds trust and thereby decreases the power differential. In light of this, these activities took place with the children in key stage 2 before the conversation began. This is crucial in adult dominated places where children have even less control (Punch 2002). Given the themes within the interviews, there was a focus on building relationships with participants to obtain valid and reliable data.
5. All of the children who were interviewed were invited to the University of Sunderland to be on the advisory group. This was to discuss key themes from the headteachers' interviews for them to give a response. Twelve children from two alternative provisions attended and verbal consent was given to check they were still happy to participate in the research project (NSPCC, 2018).

3.6.3. Recording, transfer and storage of 'interviews' and 'conversations'

All individuals have the right to be informed about the collection and use of their personal data; it is an essential transparency requirement under GDPR. As part of this duty, participants in research must be provided with information including the purposes for processing their personal data, retention periods and who the data will be shared with - this is known as privacy information (Information Commissioner's Office, 2019). All participants were told where and how the audio recordings would be stored, how they would be anonymised and that the original recordings would be deleted when the

reports were published. They were also made aware that the data would be retained in the form of anonymised transcripts and used in future publications. The right to withdraw with time frames in accordance with BERA (2018) was also made explicit.

3.7. Specific ethical considerations for the conversations with children

Careful and informed thought was given to how children could be safely included in this research project. Avoiding personal and social harm to participants and researchers is the principal aim of ethical principles and guidelines (NSPCC, 2018). However, the NSPCC acknowledges that causing harm or upset can never be fully mitigated. In liaison with the schools, 'aftercare' was discussed and processes were put in place for any child needing specific support. The main risks identified for the children were that:

- Traumatic memories or feelings about school exclusion could be reawakened
- The questions asked could potentially uncover suppressed or new feelings
- There could be a disclosure relating to child protection
- The children could worry about what they had said following the conversation

It was felt that understanding the child’s perspective was crucial for integrating the opinion of this neglected social group into the exclusion debate. To ensure the children felt safe and to negate the risks, the following processes were adhered to:

- Conversations with children were attended by either a caregiver or an adult familiar to the child, such as the designated officer for safeguarding within the school.
- Clear arrangements were in place with the host schools and researchers should there be any disclosure of child protection concerns or other safeguarding issues related to adults in the study (NSPCC, 2018).

Discussions were held prior to the ‘conversations’ about which protocols to use if the child became distressed. If the questions are appropriate for the research and the distress is not excessive, it can be considered ethical to ask them to continue if they agree (NSPCC, 2018).

- Aftercare arrangements for children and caregivers following the interviews were in place with the schools, including asking how they were feeling and asking if they had any support needs.

3.7.1. The ‘conversations’ with children

One challenge was: which age ranges should be engaged in the ‘conversations’. Following discussions with the gatekeepers, it was agreed that children in key stages 2/3 and 4 would be suited to an informal conversation. But for those in early years and key stage 1, their voice would be captured by alternative means, by the school staff, as the younger children would be more likely to be wary of strangers (Gray et al., 2004). It was important that applicable methods and questions were suited to the children’s developmental abilities and to their understanding and communication competences (Gibson 2012).

This process ensured that the children freely agreed to take part, following both caregiver and gatekeeper consent. Two children changed their minds on the day and were not interviewed. One child decided, following consent, that he did not want to have his voice recorded on the Dictaphone; he chose to draw a picture instead of what he enjoys about his new school (alternative provision). The participants all maintained the right to withdraw by June 1st 2019 without giving a reason. This was explained in all interview consent forms and information sheets. No requests to withdraw were received. The conversations were structured in such a way that the more sensitive questions on ‘school exclusion’ were in the middle, with a positive discussion about achievements and aspirations to close.

3.7.2. Upholding children’s rights

In addition to planning the research, following BERA (2018), the principal investigator also ensured the responsibilities within Articles 3 and 12 of the United Nations Convention on the Rights of the Child (UNCRC) (1989) were adhered to for the conversations with those under the age of 18 (see Fig. 6).

Article 3

The best interest of the child must be top priority in all decisions and actions that affect children.

Article 12

Every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously.

Figure: 6. Articles 3 and 12 from the United Nations Convention on the Rights of the Child

3.7.3. Withdrawing consent

Processes were put into place for any participant who wished to withdraw consent. It was made clear that they could withdraw consent up until June 1st 2019 when the data was analysed in preparation for the draft report. They were advised verbally and on the consent form of contact details and that they do not need to give a reason why. It was agreed the school staff would advise the principal director directly if any child decided to withdraw consent (BERA, 2019). No participants withdrew consent following the interviews.

3.7.4. Ethical dilemmas

The other dimension of ethics is how it is applied in a practical sense in the field of research. This concerns ethical dilemmas that are not predictable and which compel the researcher to make decisions at any stage of the research (Kutrovátz, 2017). Kutrovátz describes these situations as ‘ethically important moments’, or ‘micro-ethics’ (ibid). In this research, ethical dilemmas refer to situations during the ‘conversations’ with children when their body language changes (head down, eyes to the floor) or verbal language changes (‘mmm’, or inability to form sentences), as described by Phelan and Kisella (2013). This occurred in two interviews when the researcher began to ask about experiences of school exclusion; one child froze and another just looked away. In these two cases, it was immediately decided it was not in the best interests of the child to continue. Instead, child-led conversations took place outside of the research themes one around Christmas and another around the newly acquired school therapy dog. This highlights that formal ethical approval is not enough for managing unpredictable situations; it is the child’s, the researcher’s and the safe adult’s decision not to proceed regardless of gatekeeper, caregiver and child consent. A combination of the two approaches (formal procedures and ethics in practice) and the continuous reflexivity of the researcher are required if research is to be carried out in an ethical manner (Christensen and Prout 2002). The notion of reflexivity is

essential: Guillemim and Gillam (2004) extend its application to ethical practices when they suggest that ‘Adopting a reflexive research process means a continuous process of critical scrutiny and interpretation; not just in relation to the research methods and the data, but also to the researcher, participants and the research context’ (p. 275).

3.7.5. Disseminating research findings

Consideration was given to how to disseminate the findings in the most relevant and useful way to the different participant groups (BERA, 2018, p. 8). In discussion with the caregivers and children, it was decided that two other versions of the report would be produced by April 2020 and would be made available to all who took part.

3.7.6. General Data Protection Regulation (GDPR)

This piece of legislation is applicable only to Europe and replaced the Data Protection Act (1998). It concerns how data is acquired, held and used. This new legislation, which came into force on 25th May 2018, has brought with it increased expectations of how organisations process personal data. The key change from the DPA (1998) is around informed consent and transparency in relation to personal data usage. The intention of GDPR is not to impede research but to reflect good practice and to ensure the application of relevant safeguards (NHS, 2018). They add that organisations need to be lawful, fair and transparent when processing or controlling the processing of personal data.

Audio recordings were stored within a secure university server with access permitted to the research team only. This is in accordance with Opie and Brown (2019), who advise keeping research data in a separate storage area. The information sheets and consent forms provided for all participants are in accordance with GDPR in that they are:

- Concise, easy to understand and use clear and plain language
- Tailored to the needs of the audience
- Provided by appropriate means, for example, not everyone could access the written form, so a verbal agreement was sought.

NHS (2019)

3.8. Analysis strategy

All approaches to qualitative content analysis require a similar seven-step analytical process, including: formulating the research questions to be explored, selecting the sample to analyse, defining the categories to be applied, outlining the coding process and the coder training, implementing the coding process, determining trustworthiness, and analyzing the results of the coding process (Kaid, 1989). This section outlines the strategy to the data analysis with justification.

The approach to analysing the data began with ‘summative content analysis’, which involved the counting and comparisons of key themes followed by interpretation of the underlying content (Hsieh and Shannon, 2005). The author read all the data to immerse in the voices of the participants and to gain a sense of the key themes arising (Tesch, 1990). This is then used as a basis to derive codes when reading each verbatim transcript, organised by participant group (Miles and Huberman, 1994; Morgan, 1993; Morse and Field, 1995). The process was carried out using NVIVO Pro (qualitative analysis software), which was used to code excerpts before arranging them into developing themes. As codes emerge, they are continuously revised, merged and reviewed in preparation for analysis. The advantage

of this process was that the researcher gained information from the research data without imposing preconceived categories or theoretical perspectives (Hsieh and Shannon, 2005).

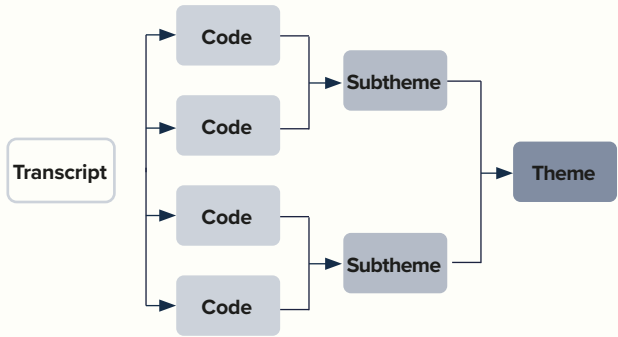


Figure 7. Iterative example of the coding process used in content analysis where codes emerge from the data.

The participant groups were coded sequentially using a coding list generated after the initial analysis of the first participant group. A coding list was used to limit the cognitive load when analysing the transcripts and to maintain reliability when analysing the large amounts of data (Morse and Richards, 2002). It should be noted that the approach was inductive, as codes were allowed to emerge from the data and were added to the expanding coding list. Examples of arising codes are given in the figure below.

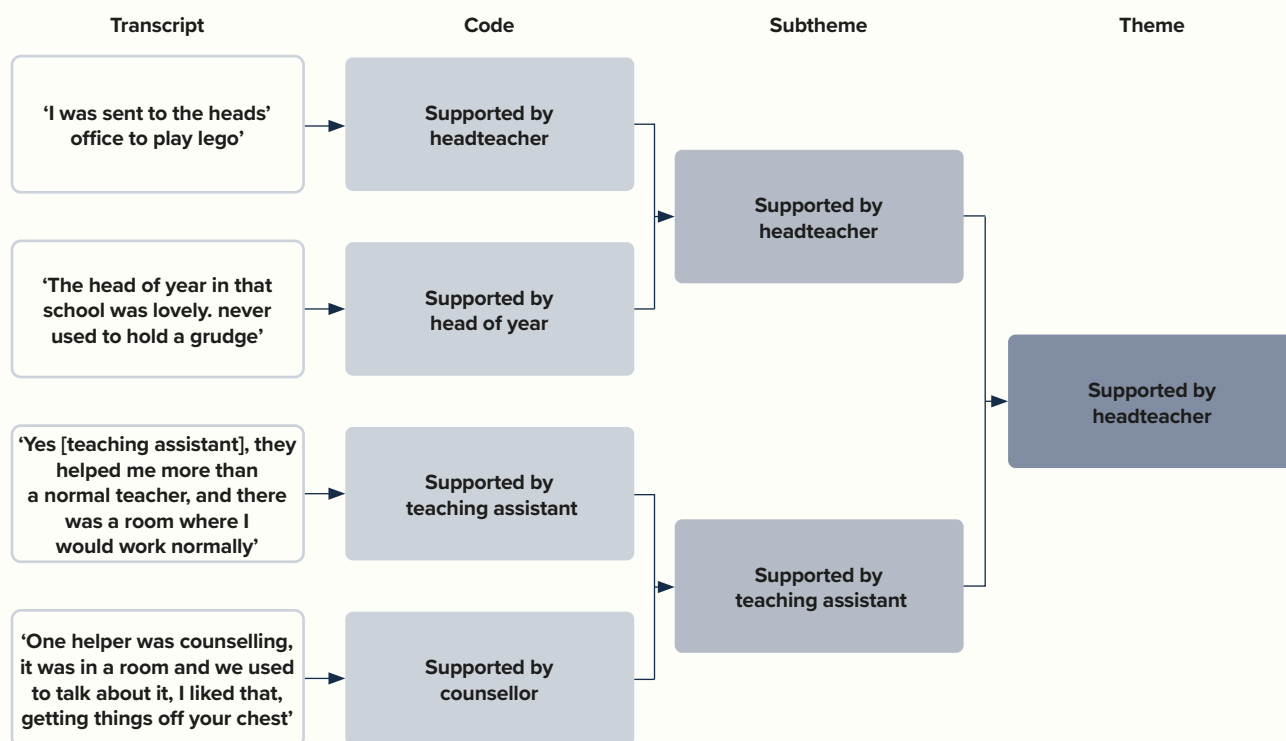


Figure 8. Example of the coding process with transcript excerpts, codes, subthemes and theme.

Usually, a limitation of this type of analysis is that there is a failure to develop a complete understanding of the context. This was overcome by the author carrying out over 50% of interviews following an approach advocated by Lincoln and Guba (1985) and Manning (1997), and debriefing from other members of the research team. Content analysis alone cannot be used to infer meaning but instead presents the usage of key terms which can be quantified (Kondracki and Wellman, 2002). The summative approach used allowed the researcher to go beyond mere word counts to include latent content analysis. This refers to the process of interpretation (Holsti, 1969), to focus on discovering the underlying meaning of the content (Babbie, 1992; Morse and Field, 1995).

3.9. Limitations

It is acknowledged that the researcher reflected on her own meaning-making in relation to the shared lived experiences of the participants. However, by adopting an inductive approach, themes were identified from the data using careful and structured means of analysis to keep descriptions as true to participants' own as possible. The research also carried out what is known as 'bracketing', where researchers acknowledge any preconceptions held throughout the research process to minimise its influence. Members of the research team were also involved in quality assuring their own and each others' transcripts, coding and analysis to avoid interpretation bias and to maintain accuracy. The questions asked to all participants were open-ended, to create the opportunity for them to share their experiences, and there were no time restrictions imposed on the length of any discussions.

Although this was a large study compared to other available research, it uses a relatively small purposive sample, based on availability and gatekeepers discretion. This means the findings cannot be generalised, as they represent the voices only of those who participated. The limitations of this research specifically include:

- The sample is not representative of children across the UK who have experienced exclusion from school
- It does not include a sample of children fully accessing mainstream education as a comparison of schooling experiences
- The views of those in the local area of Sunderland
- Only themes relating to barriers and enablers to mainstream schooling were included in this report.

4. Analysis

4. Analysis

In this section, children, caregivers and professionals reflect on the enablers and barriers to mainstream schooling.

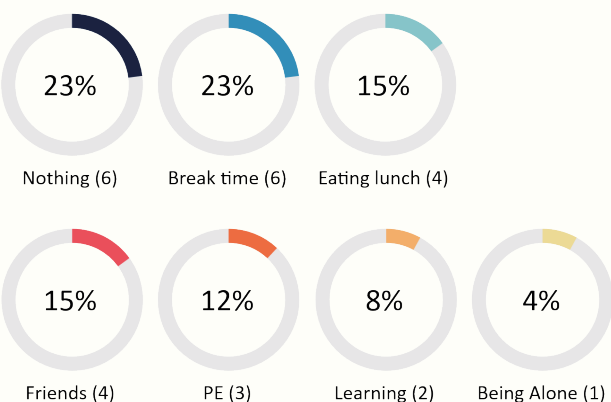
4.1. What the children enjoyed about mainstream school

Twenty-three children responded to this question:

- 20/20 children in key stage 1 (26 references)
- 3/35 children in key stages 2-4 (4 references)

4.1.1. What the children enjoyed about mainstream school: Key stage 1 children

All 20 children in KS1 were able to articulate what they enjoyed about mainstream school, making 26 references to this theme.



The most prevalent responses as to what they enjoyed about mainstream schooling from KS1 children were **‘nothing’** and **‘break time’**, with children providing descriptions such as **‘I did not enjoy anything about that school, everyone was being mean to me’** and **‘I enjoy the bouncy ball – space hopper’**. The other responses included **‘eating lunch’**, **‘having good things to eat’** and their relationships with friends **‘I enjoyed playing with my friends’**. **‘Physical Education’** (PE) and **‘learning’** were cited as elements of mainstream school that they enjoyed **‘I enjoy doing phonics’** and one

child mostly enjoyed being alone **‘everyone out of the classroom. I liked the classroom empty’**. These findings suggest children liked opportunities for social interaction and physical activity. This could indicate that some are simply not ready for the formality of school where the focus is on achieving academic targets rather than on social and emotional development (WIES, 2012; Faulkner and Coates, 2013).

4.1.2. What the children enjoyed about mainstream school: Key stage 2, 3 and 4 children

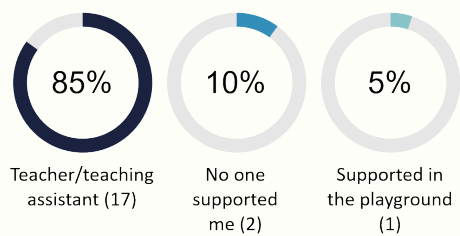
Unlike KS1, only 3 out of a possible 35 KS2-4 children were able to speak positively about any aspect of mainstream schooling. The first child, in KS2 reflected that he liked being with a non-teaching member of staff who let him ‘help with jobs around school and told jokes’. The same child also discussed enjoying playtime, particularly football, and stated that they like to be outside in the fresh air. The second child, a KS3 pupil, commented that they had enjoyed sport as they ‘could do PE, unlike English’. Finally, a child from KS4 responded that they enjoyed DT and art as they were a ‘calm lesson, something to do’. These comments suggest a positive impact of physical activity and sport on children’s emotional development. This could be due to their ability to be successful in these activities or because they are able to play alongside their peers as suggested by Sandford (2006) and Bruner et al (2011).

4.2. Children’s views of who supported them in mainstream school

In total, 32 children shared how they felt they were supported within mainstream school:

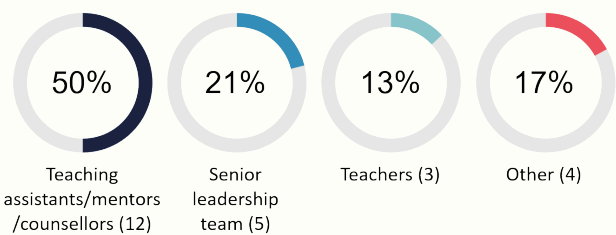
- 17/20 children in KS1 (20 references)
- 12/15 children in KS2-3 (24 references)
- 3/20 children in KS4 (6 references).

4.2.1. Children’s views of who supported them in mainstream school: Key stage 1



Of the 20 references generated by KS1 children, the most common way they recalled being supported, representing 85% of all comments, was by mainstream teachers and teaching assistants helping them with their school work. They stated that they valued the support and needed the help **‘I work best with the teacher; I only work with the teacher a little bit’** and **‘I need help in the classroom, a teacher helps me’**. This provides evidence that teachers can be a protective factor when there is a positive teacher-child relationship (Meehan et al., 2003; Martin and Dowson, 2009). Two of the children felt that no one supported them and one said they **‘sometimes get help in the playground’**.

4.2.2. Children’s views of who supported them in mainstream school: Key stage 2 and 3



There were 24 references to this question from KS2-3 children. Half said they were supported by teaching and support staff; fewer than reported by KS1 children **‘a teaching assistant from year 2, it was more help, but I still couldn’t cope’** (KS2 child) and **‘I had a member of staff just to work with me, just me. If I got upset or annoyed, she would take me out of the classroom. We had a bag of sensory toys I could play with, or we could go to the school library and read a book, so I could calm**

down’ (KS3). These responses were similar to KS1 in that children identified they needed and received support to help them cope and learn in a mainstream school environment.

Senior leaders and heads of year were also cited as a positive source of support **‘I used to go to the head’s office, she had iPads. I went there when I got wrong and she would say ‘do you want to play with me Lego and calm down?’** (KS2) and **‘the head of year in that school was lovely, never used to hold a grudge’** (KS3). The remaining references were to three English teachers and the remaining four references were mixed but mentioned a supportive member of the wider school team **‘if I was being naughty he used to come and help. When I ran away, he got me to come back in his car. Without him, I’d be bored, kicking off more with nobody to calm us down’** (KS2), **‘being outside, friends and having a quiet space to work’**. While over a fifth of the KS2-3 children interviewed cited senior leaders as a source of support, the discussions suggested that at times children were unable to cope in mainstream classrooms and that support was needed for them to access schooling.

4.2.3. Children’s views on the level of support in mainstream school: Key stage 4

Only three KS4 children out of a possible 20 were able to describe how they were supported in mainstream school. All six comments referred to support from teachers, support staff and a SENCO **‘Yes, one good teacher. She was the head of year base. She was always the one who actually listened. She would sort out problems if you had one. None of the other teachers cared’** and **‘they got this lass in to help with my behaviour. Why give me that in Year 9? Or Year 8? When I needed it in Year 7?’** The children were able to articulate that they needed support but their views imply that it wasn’t always available in mainstream classrooms. A barrier to providing consistent support for these children could have been due to resource issues and the availability of external professionals to provide advice

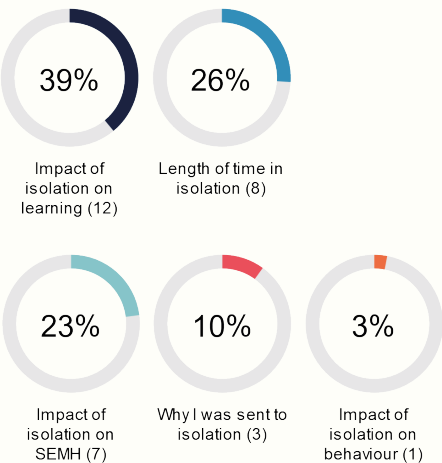
and guidance, as suggested by Johnson et al. (2017). The final comment does intimate a lack of timely intervention in the school as recommended by the Code (DfE, 2015a) as he recalls waiting two years for support.

4.3. Children’s views on the use of isolation booths in mainstream schooling

This section provides an analysis of the conversations with 27 children who shared their views of the use of isolation booths as a disciplinary sanction. This number includes an additional child, who contributed to this theme while attending a caregiver interview and consented to have his comments reported.

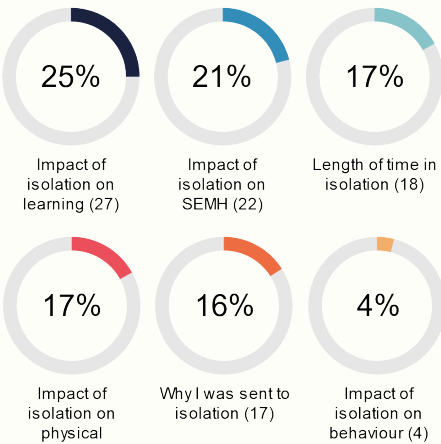
Overall, isolation booths were predominantly used in KS3 and KS4, with one child having a booth within a classroom in KS2. The number of children who spoke about isolation is given below:

- 8/15 children in KS2-3 (31 references)



Nineteen out of 20 children discussed their experiences of isolation in mainstream secondary schools.

- 19/21 children in KS4 (106 references)



Along with the 27 children who expressed their views, 19 of their caregivers participated in and discussed the impact of isolation on their child’s learning, mental health and wellbeing, and physical health.

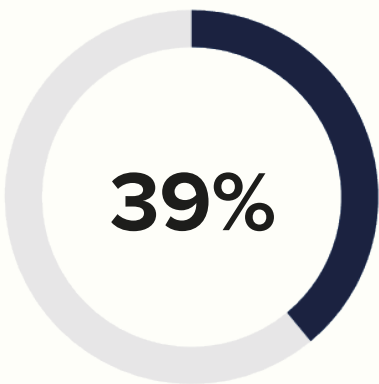
4.3.1. Children’s views on the impact of isolation booths on their learning

Overall, 27 children shared how isolation impacted on their learning:

- 8/15 children in KS2-3 (12 references)
- 19/20 children in KS4 (106 references)

4.3.1.1. Children’s views on the impact of isolation booths on their learning: Key stage 2 and 3

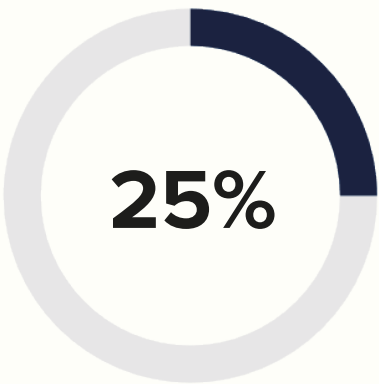
The most common theme in all of the responses relates to the perceived impact on learning due to being placed in an isolation booth. Within KS2, a child who said they were in an isolation booth within the primary classroom explained that they were faced away from the teacher during lessons **‘I couldn’t see the board or what we were learning so I had to turn around all of the time. I got sick of it’**. The other child in this age phase shared they were not in a booth but were frequently sent out of class **‘they would make me stand outside in the corridor’**. The remaining responses were all from children in KS3, with all six children recalling being placed in an isolation room with individual booths. They felt the implications for their learning were that they were ignored by staff, not taught or supported **‘not taught; they just gave you the textbook’** and **‘they just ignored you’**. There was only one child in the sample who could recall a small level of support **‘if I asked them but they wouldn’t help go through a question. They would do an example and then say they wouldn’t help anymore’**. The children’s perception was that they felt they were not supported; their learning needs were not met, even when they asked for help, supporting the findings of Nind et al. (2012) that children can feel negatively perceived by teachers.



Impact of isolation on learning (12)

4.3.1.2. Children’s views on the impact of isolation booths on their learning: Key stage 4

As with KS2 and KS3, not being taught or spoken to was a persistent issue raised by 17 KS4 children **‘they just told you to sit down and get on with your work, no teaching’** and **‘not taught, just worksheets; just had to figure that shit out for myself, but that’s life isn’t it’**. The premise of historic guidelines was that if children were placed in internal seclusion, they should have the opportunity to reflect on their behaviours (DCSF, 2008; DfE, 2015). These responses imply that some staff were not talking to children and if this was the case, it is hard to see how the cause of behaviours can be understood. During the conversations, the children were able to talk about what they learned **‘I didn’t do anything. So that is why I came to this school knowing nothing [alternative provision] knowing nothing, I was so behind on everything after two and a half years in isolation’** and **‘I couldn’t even read or write properly, because they used to kick me out of lessons’**. These views correlate with the findings of the House of Commons Education Committee (2018) that some children are left to self-teach, which contravenes advice from DfE (2016), that time spent in exclusion should be used as constructively as possible.



Impact of isolation on learning (27)

One child reported (later confirmed by the gatekeeper), that following isolation, there was an illegal exclusion **‘halfway through year 7, I got fixed-term excluded... I was only allowed in once a month; they brought me a computer home. I was home for two and a half years, mum and dad worked. I would just fall asleep’**. This would have clear implications for safeguarding the child if they were home alone from the age of 11 to 14 years. The outcome of not being taught is that children will fall behind in their learning, with severe implications for their transition to adulthood and life outcomes (Goldman-Mellor et al., 2016). This child went on to talk about how he thought the impact of not being in school explained why he could not read or write.

4.3.2. Length of time children recall spending in isolation booths

Children who responded to this question:

- 6/15 children in KS2-3 (8 references)
- 18/20 children in KS4 (19 references)

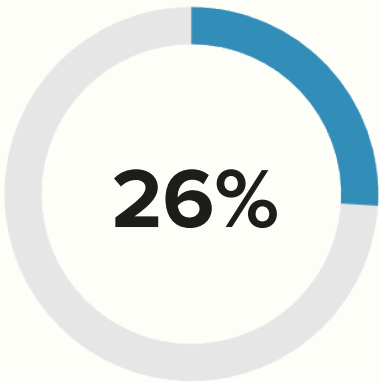
4.3.2.1. Length of time children recall spending in isolation booths: Key stage 2 and 3

The two children in KS2 reported being isolated daily **‘I have a booth in the corner of my classroom with my stuff on it’** and **‘that was my whole life really, getting sent out’**. All six KS3 children felt they could recall the length of time they were in isolation which was **‘once’** to **‘the whole day for two months’**.

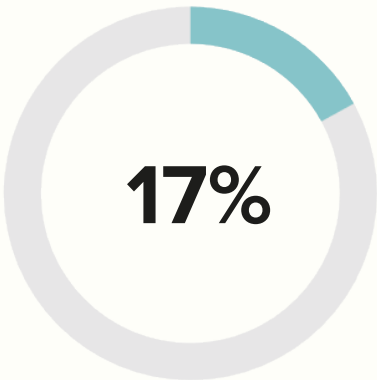
4.3.2.2. Length of time children recall spending in isolation booths: Key stage 4

What is clear from the analysis is that children in KS4 reported spending much longer periods of time in isolation compared to those in KS2 and 3 (Figure 7, below). Many described isolation booths being used as a continuous provision, with eight of the children recalling being placed in a booth every day for one to three years (Fig. 7). DfE advice (2016) allows schools to place children away from others for ‘a limited period’, which implies it is to be used for much shorter periods of time. Ofsted (2018) also clarified that children should only be in isolation for the shortest possible period. However, this was not the experience shared by some of the children in this study.

The conversations with the children insinuate that in some schools and age phases there is an over-reliance on the use of isolation booths and as a result, they feel there is limited or no education during the time they are isolated. In KS4, 19 children



Length of time in isolation (8)



Length of time in isolation (18)

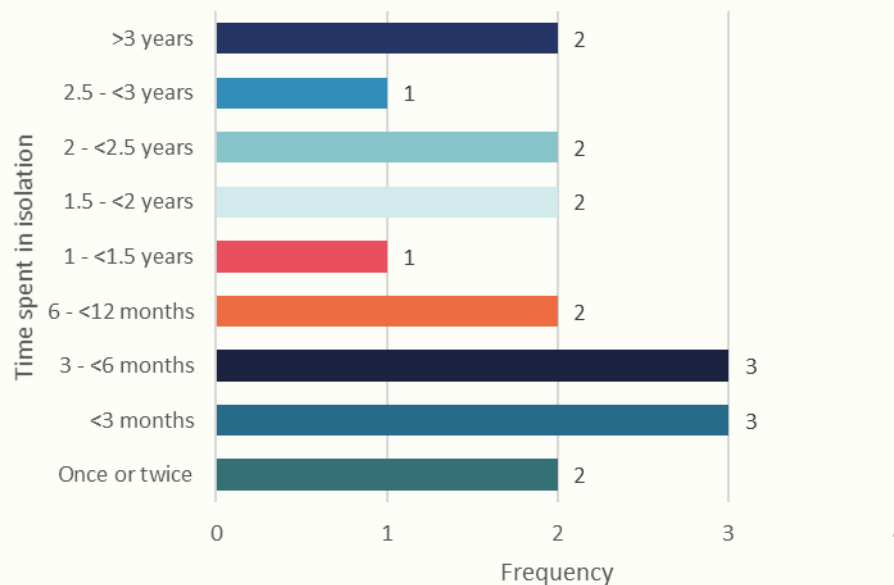


Figure: 9. Time children spent in isolation

discussed how long they were in isolation (Fig. 9) and their views imply that it is not being used as a one-off sanction but as an ongoing provision. Another child talked about being sent out of the area to another school, to be placed in an isolation booth **‘well the longest isolation that I had was like, two weeks, three weeks. So I had to go to this other school and sit in isolation. I had to go out of area, it was like one school linked with another school. Where they send different students over’**.

These findings suggest that isolating children results in less inclusive approaches to behaviour management, as they suggested they were in isolation from days to years (Gazeley 2010; West and Bailey, 2013; Gorard, 2014).

The evidence from this research suggests that for some children who are placed in isolation, they lose the right to be listened to and, in some cases, taught. This echoes findings of other research into the use of isolation booths (Sheffield and Morgan, 2017; Cosma and Soni, 2019). Given the children’s accounts, questions should be raised at a local and national level around how to manage this potential breach of the Human Rights Act 1998, in particular, article five: ‘everyone’s right to liberty’. This was clearly not the intention when ‘remove rooms’ were introduced by the DCSF in 2008; they were never intended to be used for statutory education.

4.3.3. Children’s views on the impact of isolation booths on their mental health

In total, 25 children shared how they felt isolation impacted their mental health:

- 7/15 children in KS2-3 (7 references)
- 18/20 children in KS4 (22 references)

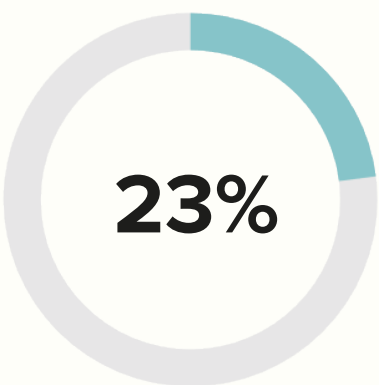
4.3.3.1. Children’s views on the impact of isolation booths on their mental health: Key stage 2 and 3

Seven children talked about their experience of being placed in isolation. Some described having restricted movement **‘not allowed out at break times, not allowed outside or to do PE (Physical Education)’** and **‘I had to face the wall’**. Two children recalled it not being too challenging an experience **‘there were three or four people with one teacher. It was actually okay’** (KS2 child) and **‘I got used to it after a while. When I first went in there I was bored’**.

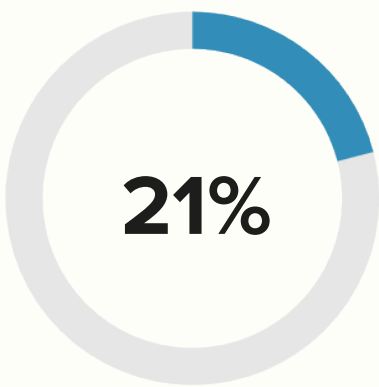
4.3.3.2. Children’s views on the impact of isolation booths on their mental health: Key stage 4

For children in KS4, their responses were similar to KS2 and 3 but the impact seemed to be more pronounced. Some reflected on the direct impact of isolation booths on their mental health using terms such as ‘depression’, ‘coping’ and ‘loneliness’ **‘it was depressing I felt alone’** and **‘I ended up quite lonely’**. This suggests that they made a link between being placed in isolation booths and their mental health, supporting existing literature by Hall-Lande et al. (2007) that suggests isolation can increase the risk of anxiety and loneliness. With current DfE (2016) guidance leaving the school to decide the duration, it seems that schools can continue to have a detrimental impact on current and future generations of children.

One child made reference to the effects of being in an isolation booth, which led to self-harming behaviours **‘I used to pull my hair out, scratch my face. I couldn’t cope with it at all. The teachers used to sit there and watch me cry’**. Another child reported that they **‘used to call it ‘the bridge’ because it made you want to just jump off a bridge’**. These comments could signify the detrimental impact of isolation booths on the mental health of children as outlined by CAPBS (2015), that seclusion can be a traumatic experience for children and can have adverse consequences on their emotional development. It also implies that the wellbeing of children is severely affected, despite a duty on schools to ensure the child’s welfare (DfE, 2016).



Impact of isolation on SEMH (7)



Impact of isolation on SEMH (22)

Similar to KS2 and 3, the children described restrictions on physical movement which they felt impacted negatively on their mental health **‘I wasn’t allowed out, no fresh air or anything’** and **‘someone kicks off, they get locked in’**. The DfE (2016) advice allows schools to prevent children from leaving isolation rooms in exceptional circumstances, although there is no legal duty to record when this occurs. The children’s comments across the key stages clearly corroborate other research, further evidencing that isolating children increases the risk of mental health difficulties such as anxiety, depression and loneliness (Hall-Lande et al., 2007; Osgood et al., 2014). There are clear indications that isolation booths and limited movement may have adverse implications for these young children. Questions need to be asked about why this continues to be a lawful approach to behaviour management across schools in England.

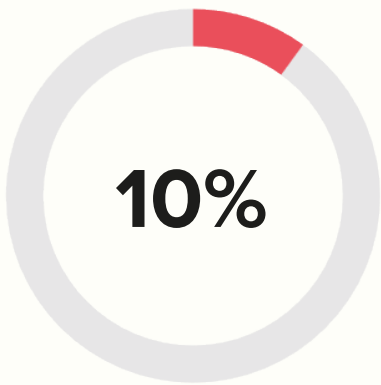
4.3.4. Children’s views on why they were sent to isolation

Overall, 20 children disclosed why they thought they were sent to isolation:

- 3/15 children in KS2-3 (3 references)
- 17/20 children in KS4 (17 references)

4.3.4.1. Children’s views on why they were sent to isolation: Key stage 2 and 3

For this age phase, there was a range of views from three respondents about why they were instructed to go to isolation. The reasons they gave included: being disruptive in class and being sent there as a last chance to remain in the school **‘isolation was if you are on your last chance in the school. It was a unit and you would go there’**. The other reason cited was **‘if you weren’t in the yard for 8.45 am, something stupid as that you get put in isolation’**. These comments suggest that there is variability in why a child would be excluded from classrooms.



Why I was sent to isolation (3)

4.3.4.2. Children’s views on why they were sent to isolation: Key stage 4

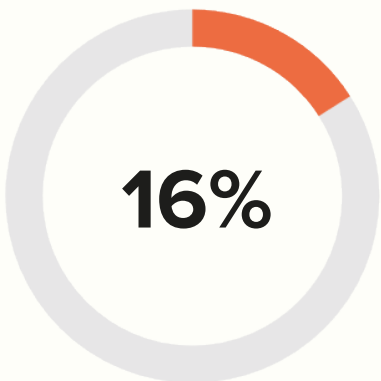
Seventeen children in KS4 talked about why they were sent to isolation. Of these, only four acknowledged that it was because of their negative behaviours **‘shouting, hitting pens off their heads. Hitting them with rulers’** and **‘it was more cheekiness and then carrying on; it got to the point where I was told ‘you are not coming into my lesson’**. The children also described how they were not asked the reason for their behaviours. Three felt they were stigmatised for previous behaviours **‘I was really naughty in Year 9, but then in Year 10, I started sorting myself out a bit. But by then the teachers just didn’t like me at all’**. This would suggest that once a child has been seen to behave negatively, they are unable to rebuild the relationship with teachers.

Several children commented that they felt they had been sent to isolation for reasons that they found hard to understand, such as **‘I had just arrived from a managed move’**, to wearing makeup, the wrong skirt, false tan, not wearing the correct shoes or being late for a lesson. Ofsted (2018) has clarified that these reasons would not justify placing a child in isolation as they would not constitute a reasonable nor a proportionate response.

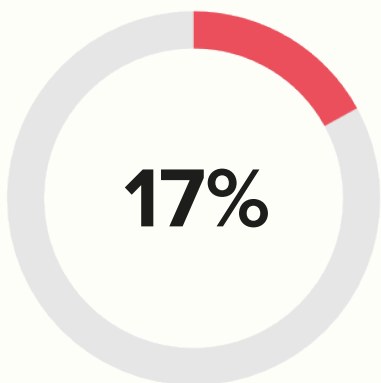
Two children described actively seeking isolation to escape what they perceived to be victimisation, to feel safe **‘I used to purposefully get myself put into what was their isolation, to avoid everyone. They used to wait outside of the classrooms for me. I used to beg my teachers to let me leave early’** and **‘I would wear the wrong skirt knowing that I would get put there. I would just do anything’**. These children felt that being in isolation was preferable to the stress of having older children waiting for them between lessons. This could indicate that procedures should be developed in these cases to support identifying the causes of underlying behaviours that children present with.

4.3.5. Children’s views on the impact of isolation on their physical health: Key stage 4

Unique to KS4 was participants reporting how isolation impacted on their physical health, with 18 out of 20 commenting. **‘I didn’t like it, it made me feel sick, they just told me to do my work’** and **‘it made me feel dizzy’**. As with KS3, it is evident that the children perceived that when they were in isolation, they were not allowed movement breaks during the school day and that movement within the isolation booths was also monitored and restricted **‘you weren’t allowed to cough or breathe loud’** and **‘you weren’t allowed to turn around or make any noises’**. The DfE (2016) advice for schools states that schools must ensure the health and welfare of children; these descriptions suggest this is



Why I was sent to isolation (17)



Impact of isolation on physical health (18)

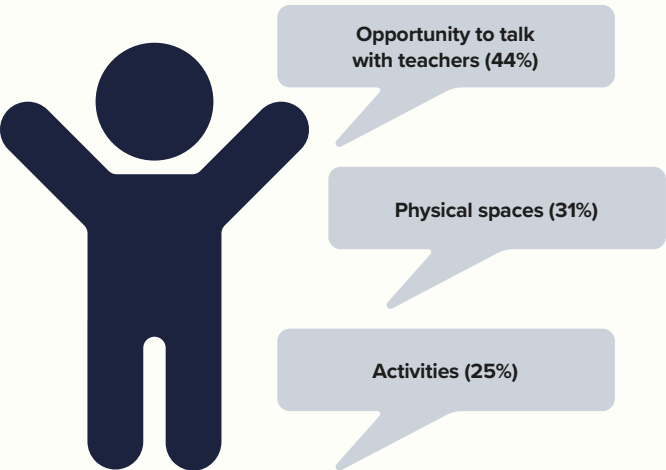
not the case. The impact on physical health due to social isolation is documented in the literature, with headaches and stomach aches reported by Lohre (2012).

Overall, the analysis of the data from children suggests that isolation for some can be a lonely and negative experience. Some felt isolation had consequences for their mental health, physical health and educational outcomes. It seems that the use of isolation booths has removed children’s sense of belonging to the school community and, due to their detrimental impact, alternative approaches need to be explored and implemented. Overall, the children’s reports imply their emotional needs were neglected (a child does not get the stimulation they need) and they were deliberately isolated and ignored. By these accounts from the children, the descriptions could be seen to fall under the definition of emotional abuse (NSPCC, 2019).

4.3.6. Advisory group of children: Proposed alternatives to isolation booths

The advisory group was held following the transcription, coding and analysis of the conversations and interviews in which emerging themes were identified. These were presented to the 12 children for discussion of their thoughts, views and suggestions of alternative approaches. All 12 children said that isolation booths do not modify or improve behaviour and in most cases, makes it worse. One child argued that some type of isolation system was needed because disruptive children should not be allowed in classrooms; the other children did not respond or agree with this view. The outcome of the discussion was that the children voted unanimously that the main change needed to improve mainstream education was the removal of all isolation booths, and this forms the basis of recommendation 1 in this report.

The comments below share the voice of the advisory group of children on what they believe would be beneficial alternatives to isolation booths in schools.



Opportunity to talk with teachers (7 references)

- ‘Take a few minutes to talk to the staff.’
- ‘Make time for us, speak to us.’
- ‘Listen to our reasons for being sent out.’
- ‘Talk to the student and ask what happened and ask what they want to do.’
- ‘Take time and take help from teachers.’
- ‘Teachers need to speak and treat students the way they want to be treated.’
- ‘Don’t automatically take the teachers’ side.’

Physical spaces (5 references)

- ‘Take you to a serene room.’
- ‘Be able to go to a calm room before being sent back to class.’
- ‘Do a calm room and more space in the isolation room.’
- ‘Let you calm down for a bit.’
- ‘Make time and places for all students.’

Activities (4 references)

- ‘Do something with them they like, to calm down.’
- ‘Leave you for a bit to calm down.’
- ‘Play games to calm down.’
- ‘Do something you like to calm down.’

The advisory group comments show that the children were able to articulate what would help them stay in the classroom and access learning and teaching. They describe a need to be left to self-regulate and to calm down, to talk to staff and go to a space they enjoy. This suggests the importance of children being enabled to manage their stress in a way that meets their needs (Ryzin et al., 2009). The solutions the children suggest would also support schools in understanding the multifaceted needs of the children through the adoption of these child-centred approaches.

4.4. Caregiver’s views on the use of isolation booths in mainstream school

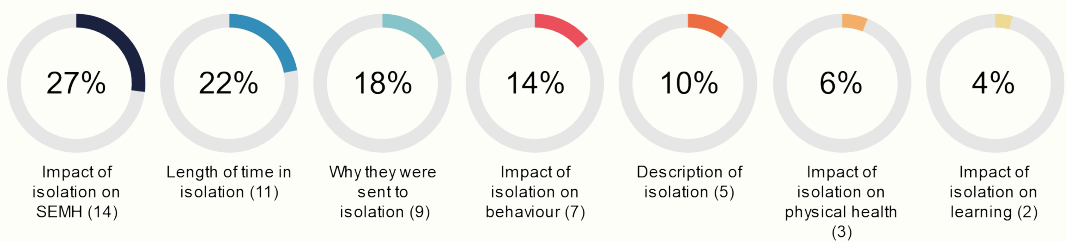
Overall, 19 caregivers shared their views on the use of isolation in mainstream school:

- 3/16 caregivers of children in KS2-3 (3 references)
- 16/21 caregivers of children in KS4 (51 references)

4.4.1. Caregivers’ views on isolation booths: Key stage 2 and 3

The caregivers reflected on their perceptions of the impact of isolation on their child **‘the teachers never gave him the time of day that he needed. He was automatically ‘a naughty boy’. So he was in inclusion, isolation mainly. Being shoved in a room and not spoken to. That would be for a lot of the time’**. The remaining two comments related to the view that there was a negative impact of isolation on their child’s behaviour **‘if you’re going to lock him up in a room, well he’ll just be like a crazed animal’** and **‘a school we know uses the term ‘lockdown’ for isolation. ‘We’re putting you in lockdown’? Wow! It’s like, come on. What type of word is that? They’ve got no windows in the room where the child goes. Then they panic and just misbehaves again and gets another day added on’**. The caregiver’s views highlight their difficulty in conceptualising the use of isolation as an approved method of discipline in schools (DfE, 2016).

4.4.2. Caregivers views on isolation booths: Key stage 4



The majority of caregivers made comments about what they perceived to be the impact of isolation booths on their child’s health and wellbeing. The main concerns they raised were their child not being able to move out of the room where they are isolated (even at lunchtime) and losing their right to liberty, **‘no breaks and not being able to communicate with teachers or peers; they don’t get break times, they don’t get lunchtimes. A cold sandwich gets sent from the main school across. They have to have all their meals there. They are there from going in till finishing school. They get no engagement, nothing, no picking their own meals’**. They discussed the impact of sitting in complete silence **‘they had to sit in silence all day. I don’t agree with isolation, sitting in silence he would come home in a complete mood. Because obviously he had sat there for hours, not being able to speak’**. One caregiver reported that the use of isolation was used against the advice of an educational psychologist and could not understand how this would be allowed to happen **‘you will have to give him some sort of break because that is in his recommendations from the Ed Psychologist. He has to have**

these breaks. You are basically torturing him. How can you expect him to work when he doesn’t have time to reset himself? When he doesn’t have a break from that room’. The caregivers all identified that the children need alternative approaches and that removing a child from human contact is not improving but compounding their mental health difficulties and behaviours **‘it’s like a prison and they are locked in the room’**. They identified basic needs, such as nurture and stimulation, for their child’s healthy emotional development, a view supported by the NSPCC (2019). Their views imply that they thought seclusion through isolation booths was not the right approach for their children (2015).

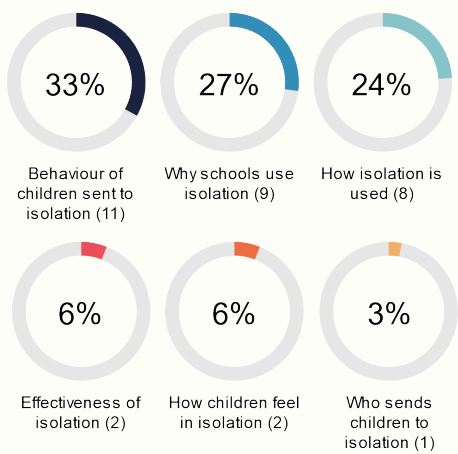
Two caregivers acknowledged their child had behaviours that, at times, were hard to support. However, they stated that isolation was an overzealous response to some behaviours **‘he threw a paper plane at his friend, he turned to speak to a friend’** and **‘for not handing his home work in, which is stupid’**. All caregivers were asked how long their child was in isolation for and their responses aligned with those of their children, whose interviews were held separately and in different weeks.

4.5. Professionals’ views on the use of isolation in mainstream school

For ease of reading the results in this section are presented by the participant group.

4.5.1. Secondary headteachers: Views on isolation booths

Of the nine secondary headteachers interviewed, all referred to isolation as a ‘behaviour management tool’, with a total of 33 references



Some secondary headteachers shared the view that behaviours of the children sent to isolation related to actions deemed to be too extreme to remain in the classroom ‘if children are not behaving to the standards we expect’ and ‘if it kicks off and they’re disrupting the learning of others and mental health problems for all concerned, we have to remove them from that until things calm down’. The language used by a few of the secondary headteachers was ‘internal exclusion...we also have internal exclusions, where they are removed from the classroom because the teacher can’t teach’ and ‘say they have had an argument with the teacher or sworn at the teacher, then they would be in internal exclusion. Years ago you would have put somebody out for that’. Some comments indicated that children could be removed for non-violent behaviours ‘if we find that a child is finding it hard to get through the door’ (come into school) and ‘so we’ll do

isolation with the head of years first if it’s not extremely violent’. The comments from the headteachers indicate that there is a range of punitive measures used in secondary schools.

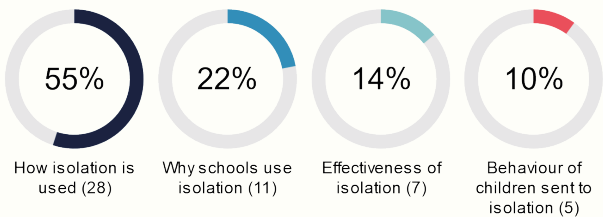
When asked why they use isolation, the secondary headteachers’ main response was to modify behaviours and to avoid fixed-period exclusions ‘they are isolated, or it’s a proper fixed term exclusion’. Some commented that children could see exclusion as a reward as they get to stay at home ‘I swear at the teacher and I get two days out; they would almost see that as a reward’. It appears that isolation booths are used for misdemeanours to prevent further behaviours ; they believed that when in isolation booths, the children would be reflecting on their behaviours, although the evidence from the children and caregivers was that it does not have this impact.

There were two references to the use of isolation booths and looked after children ‘we have isolation, if that doesn’t work we are supposed to send them home but my assistant head in charge of that area is a bit soft and will say ‘I don’t want to send him home’ or ‘he’s a looked after child’ so we sit him in the corridor outside, and say let’s contain him. But it doesn’t solve any problems’ and ‘we use isolation as an evidence-gathering tool, especially for young people with EHCPs. So they’re saying ‘we can’t manage’ so we’re saying ‘well prove you can’t manage’ and we know that our isolation room, it does have booths and we know that all the latest stuff is not to put our LAC children in there. I mean we don’t do that, but we’ve got to prove some way where they’re not coping’. It is interesting that these secondary headteachers acknowledged that they should not place looked after children in isolation and that it is an ineffective approach. The evidence from the children and caregiver interviews suggests that isolation booths are not an appropriate environment for children and indeed are not a place where professionals would be able to gather an evidence base for a child’s strengths and needs. The premise of the Code is that professionals need to understand the reasons for children’s behaviour (DfE, 2015a).

There was an acknowledgement from some of the secondary headteachers that the isolation booths are not a comfortable environment for children to be placed **‘isolation is a small boothed room which is not very nice, where they are working quietly with school behavioural managers, some of whom are leaders. They might be in there for the rest of the lesson, the morning, or the day’** and **‘a lot of students hate being in there, so they will do anything to not be in there. It’s a quiet environment. You sit there on your own in silence; they generally don’t like being in there’**. Additionally, some secondary headteachers confirmed they do not gain parental consent to place their child in an isolation booth. These comments corroborate with children’s responses, that they have their freedoms limited in isolation, in terms of limiting comfort breaks **‘we don’t exclude you from breaks and lunchtimes, we are humane (laughs) please make sure that goes into the report. We do set toilet time and we still feed people. The parents are informed and there is no parental consent sought’**. Only two headteachers reflected that they felt isolation had a positive impact on behaviour, though they did accept that this was not the case for the majority of children placed there.

4.5.2. Primary headteachers: Views on isolation booths - this was not the case for the majority of children placed there.

Overall, 23 of the 28 primary headteachers made 51 references on the use of isolation in mainstream school.



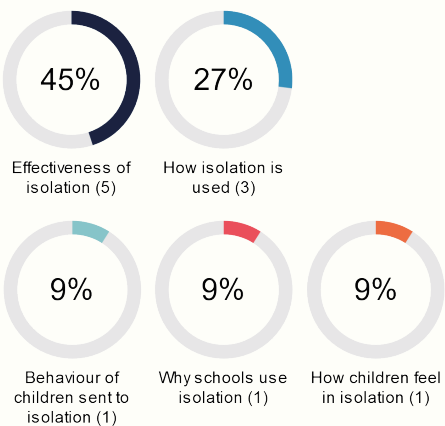
In Sunderland, two primary schools reported using isolation as a behaviour management tool in response to extreme challenging violent and aggressive behaviours **‘the first one was**

absolutely horrendous aggression between themselves and staff, and the second one was that that child has been building up a pattern... I have never had a child scream and shout at staff in the way that he did. He had escalated until he pushed a member of staff’ and **‘there are times when a child has had to be removed out of the classroom because sometimes frustration can manifest itself in throwing chairs or whatever, and at that point, the safety supersedes everything’**. The justification for the use of isolation from the two primary headteachers was related to keeping the child, other children and teachers safe, when there were no other options. This differed from the responses from some of the secondary headteachers, who seemed to use isolation for low-level behaviour disruption as well as higher-level behaviours.

Most primary schools said they didn’t use isolation but other alternative approaches that were felt to support the children to become more regulated. The types of approaches included time out, being ‘sent’ to work in the headteacher’s office, given jobs to do, toilet breaks, speaking to the school counsellor, going into another classroom and nurture/ sensory rooms. For the schools that used isolation, it was when other approaches to managing behaviour had been tried and failed **‘once you’ve followed all of your normal routes and all of your normal consequences, that would be the next step’**. There was a sense from the interviews that primary headteachers understand that children need respite from classrooms and the benefits of providing short term intervention to calm children, so they are able to re-engage with learning.

4.5.3. Nursery headteachers: Views on isolation booths

All four nursery headteachers who were interviewed spoke about isolation, making eleven references.

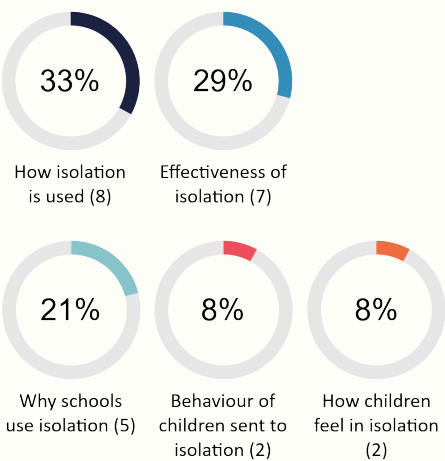


The views of nursery headteachers were similar to those of primary headteachers; that isolation was used when there was challenging, violent and aggressive behaviour **‘huge temper tantrums... scratching members of staff, biting, kicking, all sorts of things, for that child, it was appropriate to remove him’**. Similar to primary headteachers’ responses, nursery headteachers said they took children to safe spaces to calm down. In nursery schools, staff also provide comfort through physical contact **‘when a staff member could read that he was ready enough to come back then they would say ‘would you like a cuddle?’ and ‘we will come into my room and we’ll sit together and rock until she’s calmed down... At first, I did have to explain to the staff that this isn’t about us rewarding her behaviour; it’s about us supporting her to learn to regulate it. We’ve got that now’**. Nursery headteachers reported the importance of soothing, finding a comfortable place to comfort the child to show them how to emotionally regulate close to a trusted adult, an approach supported in research (Spitz, 1945, 1946, 1951; Andersen, 2008; Underdown et al., 2010, 2013; Johansson, 2013). The benefits of touch are reduced stress and a positive impact on wellbeing (Field, 2002). The importance of touch and time-in was clearly felt to be an effective and appropriate strategy provided by these nursery schools in

Sunderland. Such approaches are embedded in their policy of inclusion **‘for us, it’s very much about having an inclusion policy, not an exclusion policy. We never have time out; we always have time in because we look at children’s behaviour. If you’re excluded, you will never learn how to behave if you’re not part of the group’**.

4.5.4. Alternative provision and additionally resourced provision: Views on isolation

Alternative provision and additionally resourced provision headteachers were combined into one participant group to preserve anonymity. Nine out of ten participants shared their opinions on the use of isolation in schools creating 24 references in total. It is important to note that not all of these provisions have isolation booths in operation.



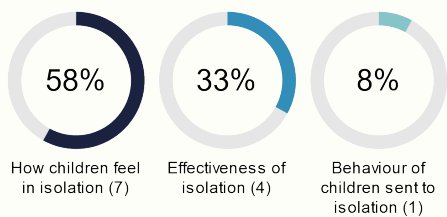
Similar to primary and nursery headteachers’ views, the alternative provision and additional resourced provisions used isolation when children were **‘having a meltdown’** and **‘hitting and kicking and screaming’**. The reasons isolation was used were: to prevent children from witnessing violent behaviours and to allow others to continue with learning. Some also said it was to ensure they knew there were boundaries in place in school **‘the last thing we want to do is take the child out; our bread and butter is around reinforcement and improving wellbeing but if we have to give warnings and consequences, we have to be quite firm and clear with that because sometimes that is**

what these children sometimes haven't had. Otherwise, they can just push the boundaries and tables go and we can't let them do that'. The views imply that isolation is the last resort, when other approaches have failed **'you would hope that curriculum support is a pro-active measure; the isolation rooms are a reactive measure... time out cards; trusted adults. All of those strategies are prevention, not the cure. But if that doesn't work, then it is the isolation'**.

Two headteachers felt use of isolation booths was justified as they had been used in other schools they were employed in **'we've got the consequences room, which is more of an isolation room; both schools that I've been head at in the last couple of years have been a very similar provision'**. The remaining participants said they did not have isolation booths but had alternative approaches, where **'maybe walk up and down the corridor to try and regulate them'** and **'space just beyond the classroom where members of staff will go and sit with them'**. There was an acknowledgement from all professionals interviewed that isolation was ineffective at modifying behaviour. They felt it was meaningless, pointless and did not address the need **'it's a sticking plaster over a haemorrhage'**.

4.5.5. Specialist headteachers: Views on isolation

With 12 references, all four specialist headteachers who took part in the research spoke about isolation as a behaviour tool in school.

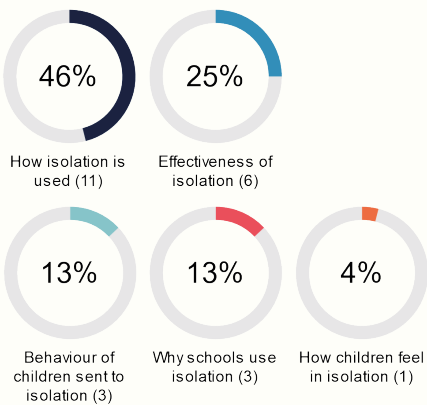


The four headteachers views corroborated those of the primary and nursery headteachers; that isolation booths were not used as a behaviour management tool for reasons such as **'they don't have the emotional resilience to deal with it'**. Some described that their schools do

have processes for removing children from classrooms, but this is to allow them to access sensory rooms, or to have conversations with staff in accessible, calming spaces about what they are finding difficult. The focus was on giving children opportunities to talk and to be listened to.

4.5.6. Special Educational Needs Coordinators (SENCOs): Views on isolation

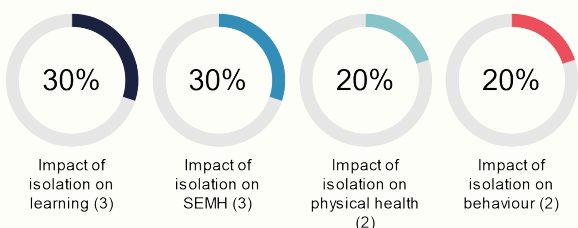
Of the fourteen SENCOs who took part, 11 shared their opinion on the use of isolation in schools, generating 24 references.



The SENCOs' views echoed those of the headteachers, in that isolation was used to manage behaviours that the class teacher was unable to cope with. This suggests that if isolation booths were removed, there will be a training need for those schools to enable them to confidently teach and support children (Carter, 2015b; NCTL, 2018). Their views were mixed on the effectiveness of isolation: **'as an immediate response when a child is having an episode to get them out of that lesson and get them back into the next one, yes I think that has quite a good effect'** and **'no, it is all SEN children generally... when it's repeating it's the same children going in the room time after time, there is no learning, no improvement behaviour and no, I don't think it works. They have identified needs not being addressed. It just helps the rest of the cohort move on with their learning. It doesn't sort the problem out for that particular child'**.

4.5.7. Health and support professionals: Views on isolation

Three health and support professionals out of a sample of nine made reference to the impact of isolation on children, generating ten comments.

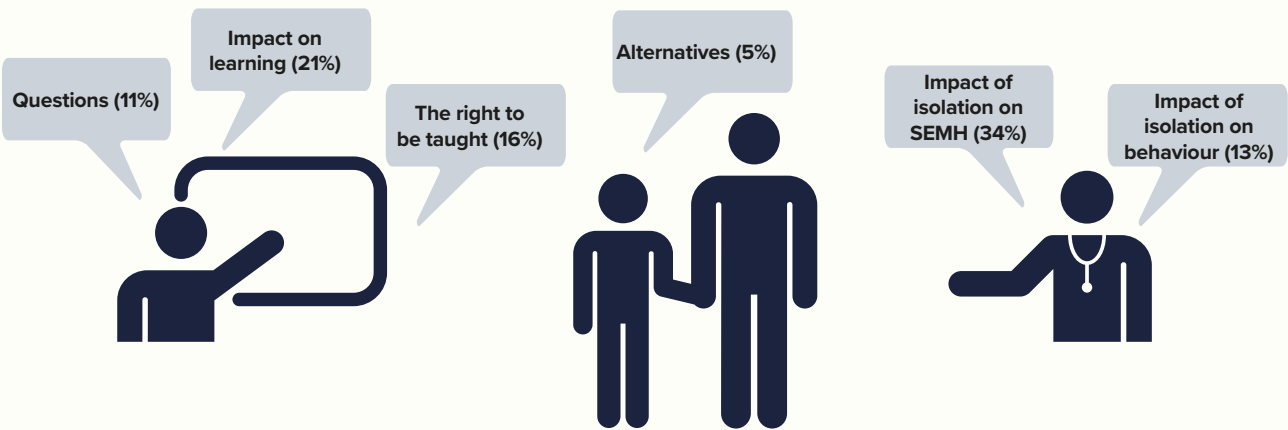


It was clear from the interviews with health professionals and support services that they were unable to understand how and why isolation booths were used in some schools. They commented on the impact on the child’s learning **‘they can bring work if they want; they don’t have to because they have lost the right to be taught’**. This view was echoed by those of the children who also stated they were not taught when in isolation booths. One participant raised the point that **‘you only need to look at the policies; it is all written down, I don’t know how they dare. I sit in schools and I look and they have prominent signs about how much education you miss if you have one day off school. But I think ‘you have just made that child sit in an isolation booth for an hour or for a whole day’. How does that work?’** Some described concern over the impact on the child’s mental health of not being

able to socialise at break and lunchtimes, and of not being spoken to when in isolation. Both of these issues were raised by the children and caregivers in their interviews and conversations with the research team. The overarching view of health and support professionals was that they felt that being consistently sent to isolation was out of the child’s control **‘you could say that the isolation booths are false imprisonment. Even detention. I know the children could walk out but there would be consequences for that’**. This suggests that health professionals feel that the children do not have liberty and freedom as legislated in the Human Rights Act (1998). They also believed that isolation does not positively improve behaviour but instead causes resentment, particularly for children who are retained for long periods of their statutory education, supporting the views of the children and the caregivers.

4.5.8. Advisory group of professionals:
Challenges, questions and concerns
around the use of isolation booths

This section shares the views of the ten professionals who were shown the overarching themes relating to the use of isolation booths in education.



The main concern identified by health and support services was that the repetitive use of isolation booths could be detrimental to the mental health and wellbeing of children **‘the impact of sitting in silence for a day, week, month or year, you just cannot imagine’** and **‘by stripping children of their dignity you are perpetrating a corrosive culture, it is dehumanising’**. They discussed the importance of social integration rather than social isolation as a means to learn positive behaviours and to prevent future mental health diagnoses. They made the point that missed education will make children further behind.

They also identified the importance of additional training in some schools that would challenge staff attitudes towards the use of isolation booths. They felt there needed to be a focus on supporting schools in identifying where a child is dysregulated, has unmet learning or mental health needs or requires

reasonable adjustments **‘what is the impact of isolation on children with regulation needs? Isolation is not a reasonable adjustment’**.

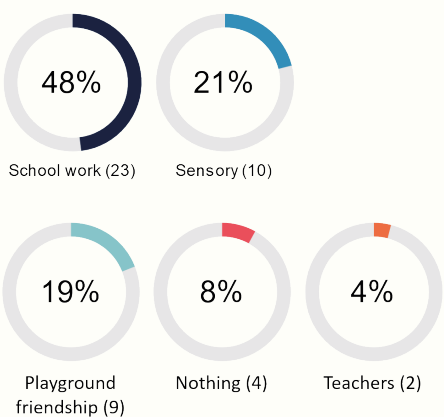
The health advisory group were concerned about the impact of isolation booths on learning; this supported the thoughts of children and caregivers and is at odds with the agenda around school attendance and attainment. The comments ranged from **‘I cannot understand why isolation is used, what purpose it serves. The quieter environment may help some, but it seems no educational instruction takes place’** and **‘why are the children contained on school premises if they have not been taught?’** They described how there was no therapeutic benefit to isolation booths and that consideration needed to be given to the curriculum if its demands are too much for some children in mainstream school with increased demand on restricted movement and less practical work (Power and Taylor, 2018).

4.6. Children’s views on additional challenges in mainstream schooling

The children were asked about what they found challenging about mainstream education.

- 20/20 children in KS1 (48 references)
- 14/15 children in KS2-3 (67 references)
- 20/20 children in KS4 (67 references)

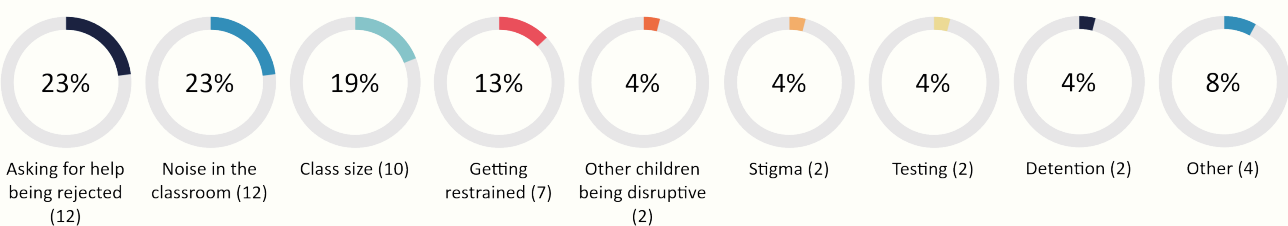
4.6.1. Children’s views on additional challenges in mainstream schooling: Key stage 1



School work was the most common response to what the KS1 children found difficult about mainstream school **‘I find it difficult to do maths ‘cos I don’t really like maths’ and ‘I find it difficult because the work is too hard’**. It was found that the majority said school work too hard, or there was too much of it to do. The remaining themes all had one response, with the children describing challenges (staying seated, too many children in the class, not liking school work, sharing, and a dislike for handwriting). This implies that these children are not coping with the day to day curriculum demands. They were able to articulate that they had **‘failed in mainstream’**, which supports the findings of both the NUT (2015) and Hutchings (2015), who found that young children are now more anxious and stressed about school, as they are required to achieve in areas of the curriculum before they are ready.

Ten responses related to sensory challenges that the children were able to describe **‘I find it hard when I am doing PE, sometimes punch people because everyone is shouting and chanting [and] it makes me angry (PE)’** and **‘noise made me feel pressure, I was upset and angry’**. Noise interfering with children’s levels of tension, leading to aggression, is supported in research (Suter, 1989). Half of the difficulties related to noise in the school and a need to regulate through screaming **‘sometimes I do scream; that’s how I stop hurting people’** and avoiding kinesthetic experiences **‘I hate the mud’**. These behaviours could be indicative of underlying neurodiverse needs (Cheung and Sui, 2009; O’Brien et al., 2009; Wiggins et al., 2009) that can impact on a child’s health and physiological and psychological outcomes (Atmaca et al., 2005). It was evident that the children found the playground a difficult place to cope in school **‘I need help in the playground because me and a child had a problem’** and **‘playground the most’**. The children’s responses indicate that noise in their environment is a barrier to accessing school; this was also experienced by the children in KS2 and 3 and is discussed in the next section.

4.6.2. Children’s views on additional challenges in mainstream schooling: Key stage 2 and 3



The figure above shows that one of the predominant challenges described by children in KS2-3 was asking for help with school work but feeling it was not forthcoming **‘there were too many people and I needed so much help; I wasn’t getting any at all, I didn’t cope well’** and **‘I say ‘can you help with this’ the person says ‘no I’ll come back to you’. But they came back at the end of the lesson or at the end of the task’**. This supports findings by Blatchford and Webster (2018) that the availability of adults can affect a child’s ability to learn. There seemed to be acceptance from the children that the teachers were overstretched, with too many children in the class to teach **‘it is hard for the teachers to get round’** and **‘they didn’t have time to listen’**. The evidence suggests that there are barriers for teachers to be able to provide the level of support that some children seek as suggested by (Johnson et al. 2017). The children discussed the impact of large class sizes of between 30 and 35 and how they felt this resulted in less support being made available **‘there were too many people in a class, up to thirty people’** and **‘there were too many people and I needed so much help. I wasn’t getting any, at all. I didn’t cope well. So I would kick off a lot’**. The idea of not coping has been found to be linked to larger class sizes, particularly for children who have SEMH needs and lower levels of attainment (Smith and Glass, 1980; Blatchford et al., 2011).

Over half of the children reflected on the impact of lack of support on their self-esteem and well-being. As with KS1, it was evident with the children in KS2 that remaining calm was difficult due to high noise levels, which correspond with other research (Atamaca et al., 2005;

Kanakri et al., 2017). Children’s comments show the adverse impact of noise on their ability to engage in school **‘it stresses me out. I feel I start to go crazy. When I’m angry that I feel like I’m going crazy’** and **‘the fire alarms there are so high pitched. That’s why I’m glad I’ve left. The fire alarms’ went off a lot and it’s a lot, a lot of noises’**. This supports that early assessment and identification of the multi-faceted needs of children is a crucial aspect of maintaining access to mainstream education.

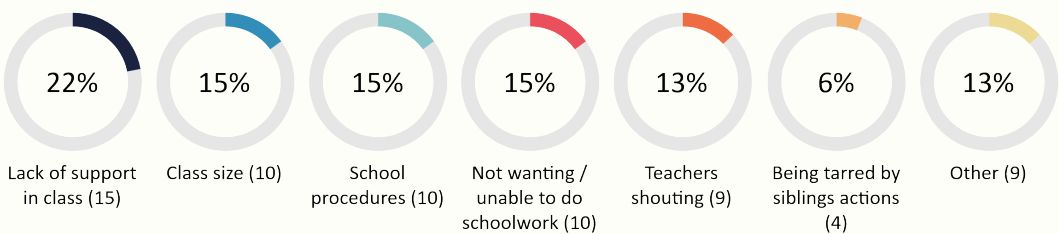
During the conversations with children, they described how they were restrained in school, **‘they would have my arms like ‘that’ and someone was on the other side, pulling my arms. Or they would have one person pushing my arms down, one would push my knees and one would push my feet’** and **‘for my arms, knees, feet, there were three. Just the arms was only one’**. It is clear from the evidence that the children disliked restraint and that it is being used in both KS2 and 3 but interestingly, was not reported in KS4. In all of the interviews when restraint was discussed, the children’s demeanour changed as they reflected on this as a disciplinary approach. All four children talked about it making them feel worse, distressed and angry **‘it made me more mad’**. The descriptions from the children on why restraint was used varied; one child described it following a fight with another child; after having her hair pulled, restraints were made on both children. Two children reflected on the reason being that teachers anticipated they were about to do something wrong due to changes in their behaviours **‘cause if you do something wrong, you get restrained straight away. Like if someone went to hit you and you**

walked away. When they start coming at you, they would just if you reacted a different way they would restrain you' and 'just have to be naughty, just do it sometimes if you react in a different way'.

The DfE (2013b) clarified that restraint is only to be used in extreme cases such as fighting. The children reported feeling that restraint was not justified and that they needed to simply be able to self-regulate **'so when I was angry, I used to go out the door and run around the track to keep us calm, one day three teachers chased me'**. These comments from the children indicate a possible training need so that signs of a child becoming dysregulated are better understood, so restraint can be avoided. The model used in health should be applied to education, where schools have restrictive intervention reduction programmes, as new approaches are explored and embedded (DoH, 2014). Alternative methods are available, such as those taught by Studio 3, which is endorsed by the British Institute of Learning Disabilities (BILD), as it promotes schools negating the need for physical restraint. This should include understanding the underlying message conveyed by the child's behaviour (American Psychiatric Association, 2013).

Other additional challenges reported by these children were due to perceived pressure **'every time the times tables get quick... I used to get one out of ten and others get ten out of ten, but they were too big and there was a timer, you had to read how many you got in front of the class'**. Detention, stigma and other children being disruptive were referred to twice each. Changes to routine, getting sent out **'that was my whole life really, getting sent out'** teachers and competitive use of rewards were each referred to once.

4.6.3. Children’s views on additional challenges in mainstream schooling: Key stage 4



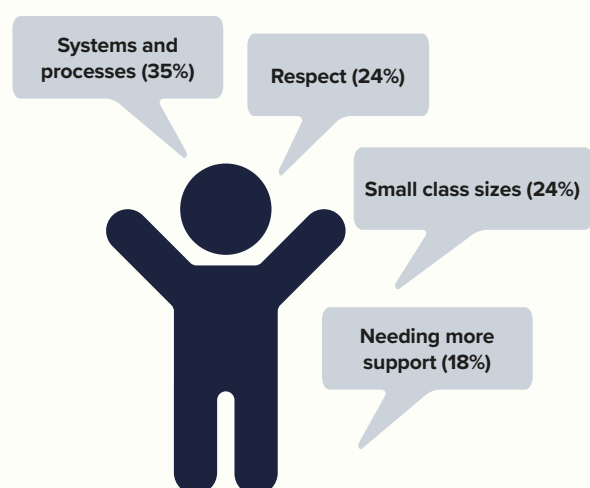
In KS4, all twenty children made comments on additional challenges with 67 references. The most common difficulty in mainstream education, accounting for over 22% of responses was the lack of support **‘they didn’t support me, so I was going home crying... because they weren’t helping me through anything, they just told me to get on with it’** and **‘the fact is when I asked for help they wouldn’t give it to me, they would just say ‘I will come back to you’**. The comments suggest that children need a personalised curriculum and teaching approaches to support them in accessing and participating in the learning, as proposed by Michale and Frederickson (2013), and Tellis-James and Fox (2016). It suggests that the lessons are not accessible given the needs of the children and that they need a strengths-based approach.

Another challenge reported in KS4 was that class sizes were too large for children to be able to learn and access support **‘thirty children and only one member of staff to support them’** and **‘they can’t get round a class of thirty, just helping one child all the time’**. This view was also an issue for KS2/3, and supports the findings of Blatchford et al. (2011), that classroom engagement decreases in larger classes, as does teacher support for learning generally (Graue et al., 2008). The children’s comments suggest they disengage because they are unable to understand the lessons or activities presented to them; this results in them not completing the work and the cycle of sanctions begins and ultimately results in them not remaining in the classroom. Unlike some findings, which suggest that teachers make more of an impact on learning than class size (Sanders et al., 1997; Blatchford et al., 2011), a common theme here is that children need smaller classes to access the support they need.

School procedures represented 15% of references to barriers to mainstream schooling experienced by KS4 children. These predominantly referred to perceived breaches of uniform **‘he came into the school and tried to change too much; he would make us line up on the morning break and dinner to make sure we were all checked’** and **‘we would be outside for twenty minutes to make sure we had our coats and correct uniform... I was always pulled out of the line and had to wait for the headteacher because I was talking apparently’**. There is a clear perception of unfairness from the children in relation to school procedures, feeling they are watched and checked constantly, with only one child accepting that it was deserved **‘I was proper lively like. I used to get wrong for doing things I shouldn’t do all the time. All the way through school. But I’ve learnt how to control it more in secondary’**. These comments support the views that discipline systems and policies in schools do not consider normative adolescent behaviours and child development (Gregory and Cornell, 2009; Kupchik and Catlaw, 2015). The children’s comments imply that some teachers and/or senior leaders are seeking out children who are not appropriately dressed. For some children, there may be a deliberate attempt to not adhere to uniform regulation but for others, there may be no choice due to factors such as low family income, working caregivers, if the child has grown or if they do not have the motor coordination to tuck in a school shirt. In acknowledgement of these reasons, the House of Commons (2018) called on schools to use zero-tolerance approaches for drugs or weapons but not for minor infractions such as uniform violations.

4.6.4. Advisory group of children: Challenges encountered in mainstream school

The advisory group was held following the transcription, coding and analysis of the interviews, which identified emerging themes. These were then presented to the twelve children for discussion. The main concern they had with mainstream school was the systems and processes relating to behaviour management.



Needing more support (three responses)

- ‘Be fair and give more support in lessons.’
- ‘To have teachers that actually understand learning difficulties.’
- ‘Have more ways for children to cope (self-regulation).’

Respect (four responses)

- ‘Teachers need to respect us if they expect it back.’
- ‘Teachers need to give respect to receive it (stop using their power to belittle students.’
- ‘Teachers to have a better attitude towards children.’
- ‘Schools need respect for children.’

These views indicate that some children feel unable to cope in large class sizes and they desire more support in lessons to support them to participate and learn. They also request that they are given ways to self-regulate and that having teachers who respect them would improve their attitude towards school.

Systems and processes (six responses)

- ‘Teachers need to pick their priorities (I got isolated for not having my shirt tucked in.’
- ‘No more isolation.’
- ‘Take away isolation booths.’
- ‘Take isolation out of schools.’
- ‘Try to understand the problem rather than dish out punishment.’
- ‘You should be able to express yourself and not be punished for things that have nothing to do with learning.’

Class size (four responses)

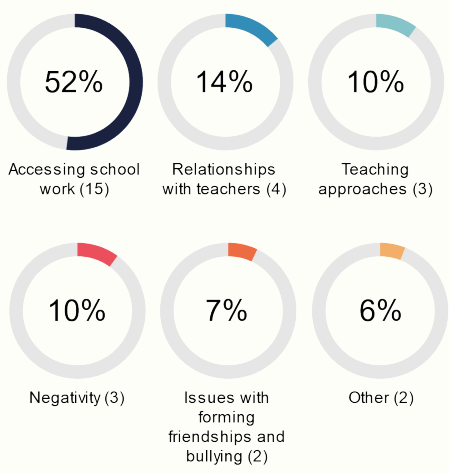
- ‘You can’t cope in big classes; there are too many people and you cannot get any help.’
- ‘Smaller classes are not as loud.’
- ‘People distract you.’
- ‘People might get on your nerves.’

4.7. Caregivers’ views of the challenges their child had in mainstream school

Thirty-one caregivers shared what they felt their child(ren) found difficult in mainstream education:

- 13/20 caregivers of children in KS1-3 (83 references)
- 18/21 caregivers of children in KS4 (89 references)

4.7.1. Caregivers’ views of the challenges their child had in mainstream school: Key Stage 1, 2 and 3



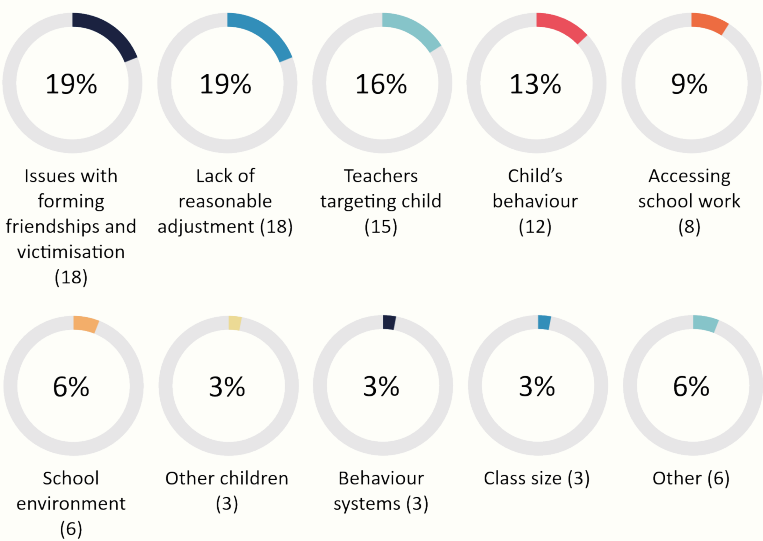
Of the 20 caregivers, 13 commented on what their child found difficult in mainstream school. The majority described how they felt their children were struggling with accessing school work, recognising that their children do not have the academic ability and/ or support needed to succeed **‘it gets a bit more academic sort of thing; he was finding it really hard and that’s when the issues arose’** and **‘he started struggling with his work, he didn’t have the confidence’**. The views support those of the House of Commons (2018b), who acknowledge the increasing pressures children are under. It could be that for some children who are unable to manage the academic demands, there needs to be consideration of adopting an alternative approach for secondary education, such as the Swiss vocational

education and training model advocated by Basler and Kriesi (2019). This could give children as young as 12 options to follow alternative tracks into training programmes alongside a school education.

In the caregiver responses, 14% referred to their perception that there was a breakdown of relationships between the teachers and their child **‘he didn’t trust any of the teachers; there was no relationships, they’d all broken; they wrote him off, he knew that’** and **‘he didn’t like how they made him feel and how they treat him’**, with some comments specifying the negativity from the school **‘every report he was getting from school was negative, never any positives’** and **‘every report from school was negative, negative, negative’**. The caregivers’ views were that the relationships in mainstream school had broken down, supporting other findings whereby children felt negatively perceived by the teachers (Nind et al., 2012; Michael and Fredrickson, 2013; Sheffield and Morgan, 2017), and that teachers focus on negatives and ignore the positives (O’Connor et al., 2011).

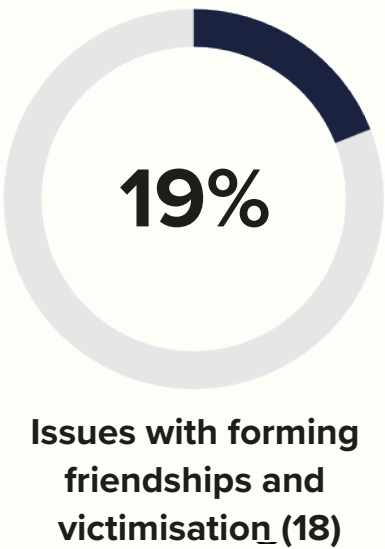
4.7.2. Caregiver’s views of the challenges their child had in mainstream school: Key Stage 4

This data set represents the views of 18 caregivers of children in KS4 with 92 references to this theme. Due to the large data set on this theme, it is presented by each subtheme.



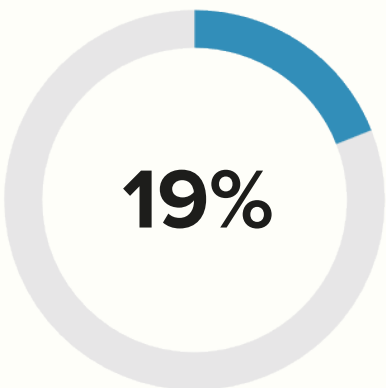
Victimisation

Within the caregivers’ responses, some perceived that their child was not accepted by other children or that other children were able to identify differences that led to their child being targeted **‘because the children then knew he was different, then they had a target of someone to bully, someone to wind up. They thought it was funny when he went bang’** and **‘he told me that the three boys had been mouthy earlier on in the day. They called him ‘a scummy care kid’ he said ‘I’m not going to be called those names. You know what it is like for me’ They said to him ‘your mum didn’t want you’.** These comments suggest there could be issues with victimisation in some of the secondary schools and that particular children are being targeted as they are perceived to be different. There needs to be consideration of the impact of such comments on these children and their emotional wellbeing.



Lack of reasonable adjustment, support and understanding of the child’s needs

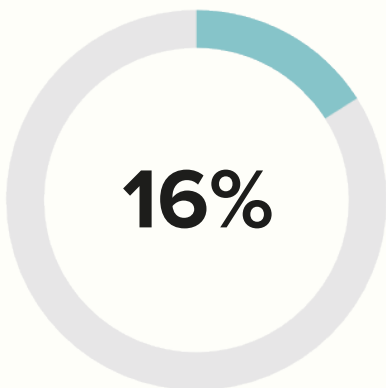
Most caregivers intimated that the challenges their children encountered in their mainstream school were due to underlying and undiagnosed disabilities, traumatic life events, neurodiversity or learning disabilities **‘CAMHS gave him a fiddle toy. But then teachers took them off him and said they were ridiculous and put them in the bin. He would get frustrated because they would take away the coping mechanisms’** and **‘for persistent disruptive behaviour, for tapping, tics and for making stupid noises. He tics when he is nervous’**. Two caregivers with children with a diagnosis of autism felt their literal interpretation of meaning from adults was not understood by teachers **‘if they got a specific [detail] wrong, he would say that he hadn’t done that’** like **‘you threw that out the window’** then he would say **‘no, I threw it at him and it went out the window. It bounced off him and then out the window.’** So they would put him in **detention for arguing’** and **‘my child asked if he could give his honest opinion about something and was told yes. When he gave his opinion, he got in trouble’**. One caregiver described how she felt several changes in significant adults in school led to difficulties in mainstream education **‘his social worker, who had been his original social worker from coming into care left. His pastoral worker at school left, they were massive losses for him’**. All of the responses to this theme suggest that maybe schools need support in assessing, identifying and responding to children’s holistic needs and this needs to include understanding adaptations and the application of reasonable adjustments as directed by Equality Act (2010) duties.



Lack of reasonable adjustment (18)

Teachers targeting the child

Some caregivers felt that their child was targeted by teachers and headteachers and that once their child misbehaved, they were stigmatised as a badly behaved child **‘a new head started and he seemed to target those with additional needs. Her dad was aggressive, so she had upheaval because of domestic violence. The head would get in her face and provoke her’** and **‘his coping mechanisms is to just leave rather than there be a massive argument. This is what we do at home. It was working but the teachers then tried to make him stay. They would step in his way, put their arm out and block his way. Then say that my child has barged them. But my child wouldn’t even touch them. He would deliberately walk under their arms’**. The responses also included caregiver concerns that the actions of schools can trigger historical traumatic adverse childhood experiences which lead to perceived negative behaviour as a response. This could demonstrate a potential lack of understanding of ACEs and trauma-informed approaches as advocated by Thorley and Coates (2018) and Martin-Denham and Watts (2019).



Teachers targeting child (15)

Managing their own behaviour(s)

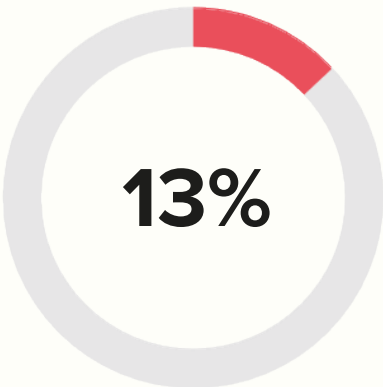
Many of the caregivers cited that their children’s difficulties in mainstream school were due to how the child’s behaviours presented at school. Their comments suggest that they agree their child’s behaviours were challenging **‘he was aggressive towards the deputy head’ and ‘shouting out, carrying on. Fighting. Everything, he was taking drugs’.**

Accessing school work

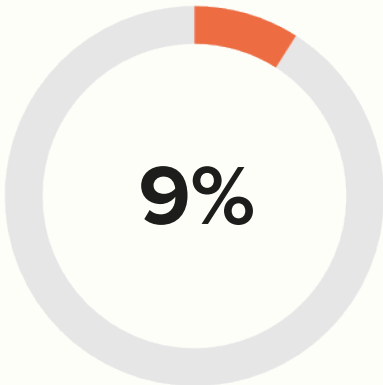
All of the responses to this theme related to the caregivers describing how their child was unable to access the school work as it was too challenging **‘When it came to work, if he couldn’t do it then he couldn’t do it. He would fling his book to the side. ‘I can’t do it.’ I think quite a lot of frustration was because he couldn’t do the work’ and ‘he started to fall behind in juniors. He isn’t academic; he fell behind a lot. He wasn’t understanding. His behaviour started, it was a cycle’.** This supports both the children’s views and the literature, in that when children are unable to manage the school work presented to them in a learning style they cannot access, they disengage (Dunlap et al., 2006; Ewen and Topping, 2012).

School environment

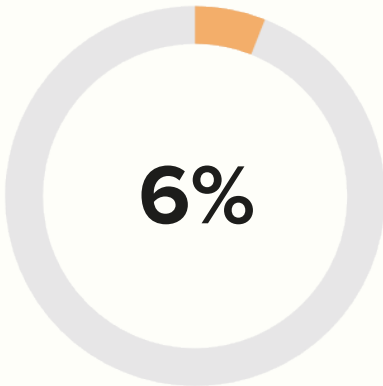
These responses related to the caregivers’ view that the demanding environment of mainstream school requires children to be fully compliant at all times and to attend to learning **‘the expectations of, not behaviour, but of conforming readily, all of the time. Sit. Speak. Work’ and ‘in a mainstream school, where you can’t even speak in class and they put you in inclusion. I think a lot of mainstream schools just focus on getting the grades. Rather than having a little bit of fun within school time. Not just having to sit there, sad, in total silence’.** The comments from caregivers suggest that their children have ongoing pressures which impact on their ability to conform (Martin-Denham, 2019).



Child’s behaviour (12)



Accessing schoolwork (8)



School environment (6)

The remaining themes related to the caregivers' views on challenges their KS4 children had in mainstream schools:

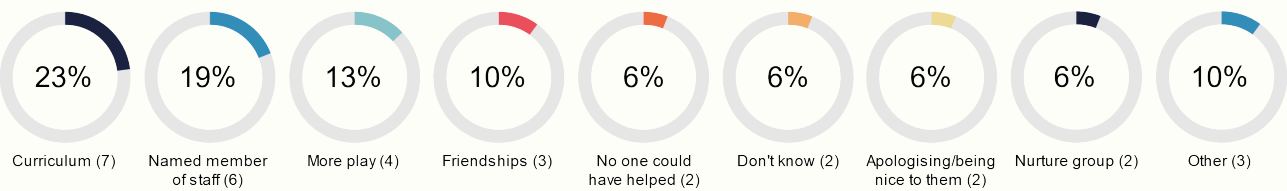
- Other children (3% - 3 references); feeling their child was easily led into negative behaviours by other children
- Behaviour systems (3% - 3 references); being punished by missing PE (their favourite subject), for too many points, wrong bag, not handing in homework...
- Class size (2 references); too many children in the classroom for teachers to meet individual needs
- Previous traumatic experiences (2 references)
- Transition to a Multi-Academy Trust regime (1 reference)
- Smoking and drug misuse (1 reference)

4.8. Children's views of what could have enabled them to stay in mainstream school

The children were asked to reflect on what would have enabled them to stay in mainstream school. There were 83 responses to this question from 42 children from KS1-4; these are analysed by age phase below.

- 17/20 children in KS1 (31 references)
- 13/15 children in KS2-3 (30 references)
- 12/20 children in KS4 (25 references)

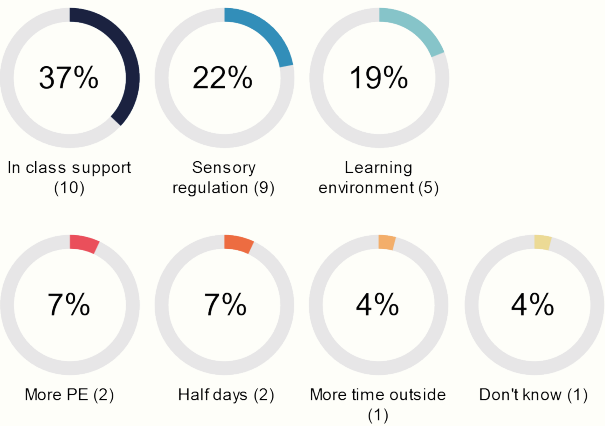
4.8.1. Children's views of what could have enabled them to stay in mainstream school: Key stage 1



The key change identified by children in KS1 that would have helped them stay in mainstream school was perceived to be a change to the structure and content of the school day **‘shorter school days’** and **‘I could have been helped by going to nurture group’**. The children articulated their emotional needs that needed to be met **‘cuddling makes me happy’** and **‘having time to talk room’**, which may not be available in all schools currently due to staffing and funding limitations. Some comments related to them asking for support with behaviour **‘help me make good choices’**. Some children were able to describe what they needed to be able to self-regulate in school **‘to bring in teddies and fidget cubes’** and to give them focus **‘if I had some targets; I have targets now’**. The children were able to articulate what their needs were in school. This shows the importance of listening and responding to children’s views (DfE, 2015a).

The second most common response related to additional support from staff (19%). This was followed by more play (13%) and secure friendships (10%) **‘to not be excluded I could be helped by my friends. Because they said if you keep being naughty, you will not see us’** and **‘having more and more friends’**. The remaining four references were children who were not able to say what could have helped them, or believing that no one could have helped them stay **‘I don’t think anything could help me not get excluded’**.

4.8.2. Children’s views of what could have enabled them to stay in mainstream school: Key stage 2 and 3



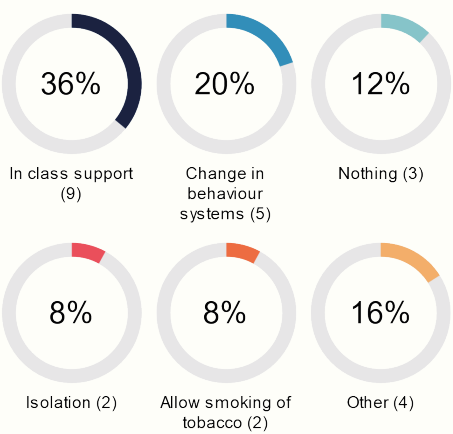
The main theme that emerged (37%) was the children describing that they needed better in-class support, both with learning and managing their own behaviour **‘if someone had sat and explained the work, I would have done it. I would have understood it’** and **‘If they had given you a list, like a PowerPoint. It tells you; you need to do this, then this and this’**. **‘I need more staff helping, explaining things, maths was the only lesson I could get because I have dyslexia, they weren’t helping with that’**. As found by Cosma and Soni (2017), this suggests that educational provision is not appropriate for the child’s needs; that pressures are too high and the support is too low. One child explained that if they were restrained less, that could have helped them stay in mainstream **‘maybe not restrain me as much’**. Alternative approaches should be explored, such as building trusting relationships, understanding triggers and identifying solutions and defusing and distracting the child (Ofsted, 2018, p. 3).

Other comments suggested adjustments to the learning environment and being allowed to self regulate **‘if you are annoyed, you can take it out by playing the music. You can explain yourself through the music, instead of taking it out on other people and hitting walls’** and **‘definitely a quiet room. Not noisy and stressful. I would say put me in lessons where I know people. Where I get on with them, even just a few weeks to get settled in’** and the need to accommodate sensory regulation **‘It’s something to do, even in my lessons, I take apart my pens. I fiddle all the time’**. These comments suggest that local training is needed to ensure those working with children are equipped to support the mental health and wellbeing needs of children (DfE, 2015b).

An additional sub-theme within sensory regulation was that the children felt they were unable to cope with teachers who shout **‘the more they shout, the more I shout’** and **‘teachers not shouting when they think they are big, stop screaming at us’**, they felt this caused an escalation in behaviour. The final comments related to their need for exercise. Two children suggested **‘I wasn’t going to run out of school I just wanted to go on the track. I prefer to be outside. I like fresh air and doing outdoor stuff’**

and ‘football calms me down when I am with my friends’. Finally, two children said they needed a reduced school day either through a reduced timetable or half days. The remaining child was not able to articulate what could have helped them.

4.8.3. Children’s views of what could have enabled them to stay in mainstream school: Key stage 4



As with KS2-3, the children felt that the main change to help them remain in mainstream education was more in-class support (36%) ‘talk to me and help with my work, they wouldn’t help me, then I would end up kicking off, distracting people because I had nothing to do’ and ‘give more support with work instead of removing from lessons’. These views also support those of the caregivers. 20% suggested changing behaviour management systems ‘not to be so harsh on every single thing you do. What difference does it make if your shirt is out or in? It’s not going to affect how you learn’ and ‘I go from C1 to C5 in ten minutes’. This indicates that there needs to be some flexibility in behaviour policies and provision for additional support. The remaining responses related to preferring isolation to lessons ‘I liked isolation more than my lessons’ and quicker diagnosis ‘if I had gotten it earlier I might have stuck mainstream better’.

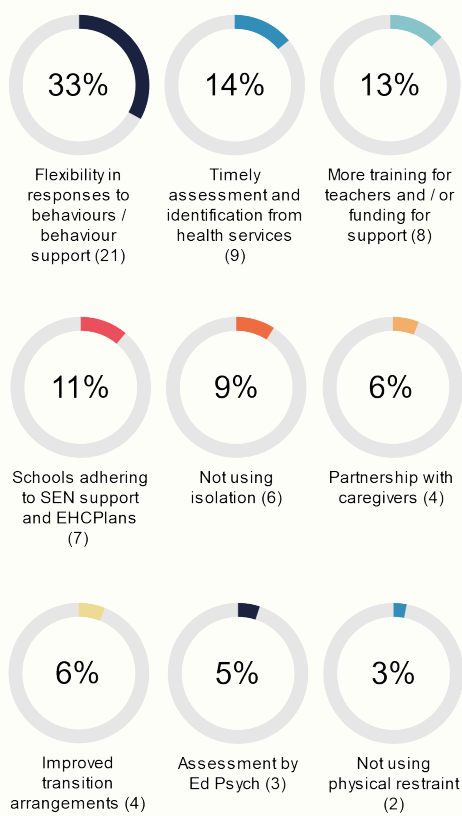
4.9. Caregivers’ views on what could have prevented the permanent school exclusion(s)

Twenty-seven caregivers shared what could have prevented their child(ren) from being excluded:

- 13/20 caregivers with children in KS1-3 (64 references)
- 14/21 caregivers with children in KS4 (46 references)

4.9.1. Caregivers’ views on what could have prevented the school exclusion(s): Key stage 1, 2 and 3

Thirteen out of the 16 caregivers who felt the exclusion could have been prevented, with 64 references.



Caregivers felt that the main change that could be made to prevent the permanent exclusion was for schools to have flexibility in the application of their behaviour policies. Their views alluded to the fact that schools did not understand their child's needs and that their behaviours in school escalated because of this. They also felt schools did not listen to their concerns and suggestions of how to respond to the child when they were dis-regulated **'they needed to listen. They were very quick to just say he was naughty' and 'listen to the kids when they get a bit silly in their chairs, they can't sit still. Now's the time to take them out, to make them run around the field a couple of times'**. Some caregivers described how the school did not understand the impact of diagnosed conditions on their child's ability to 'conform' and adhere to behaviour expectations **'he was just classed as the naughty boy. I don't think they understood his syndrome' and 'fidgeting as well... They try to get him to stand in a line, we know he's not going to stand still, so he gets told off and he gets detention. But they know he can't do it. So why make them?'** The general consensus was that if the teachers had a better understanding of the child's needs, they would be equipped to support them effectively and to identify when flexibility to school processes should be applied.

The importance of having detailed plans to support the transition between key stages and classes within a school was suggested as an improvement to current mainstream practices. One caregiver discussed the impact of transition plans not being in place and their view that this was a key factor in the mainstream placement failing **'they didn't find out from the infant school how they managed him. They didn't put any support in place. They didn't put any timeout breaks in place, no sensory support in place. I mean nothing I literally mean nothing. So, he was dumped into a classroom with 30 odd children and left to get on with it. It went downhill drastically and very quickly'**. The comments by the caregivers justify a need for a review of training to prepare teachers across key stages to provide evidence-based approaches to **support children with multifaceted needs 'they need training. They need to understand not just the strategies but how to apply them' and 'go and**

do a course to understand sometimes their reaction is anxiety'. In light of the evidence presented, this should also include training on preparing for and implementing transition arrangements.

The second most cited view from caregivers of how to prevent school exclusion related to the need for timely assessment and identification from health services. The caregivers knew their child had difficulties but felt there were barriers to gaining access to appointments with medical professionals, such as being turned away by General Practitioners (GPs). **'Doctors pushed me back to nursery staff who pushed back at me, I had nowhere to turn'** or waiting too long to be seen by Children and Young People's Services (CYPS) **'my first response from CYPS took a year'**. A frequently reported issue from caregivers was that they felt, when raising concerns about their child to a GP during the preschool years, they were advised to wait a few years before returning to request a referral **'I was told to wait until he was five; he was only three. As soon as he was five he was permanently excluded'**. This indicates that the caregivers perceived that their concerns were not always listened to and because of this, they were in limbo.

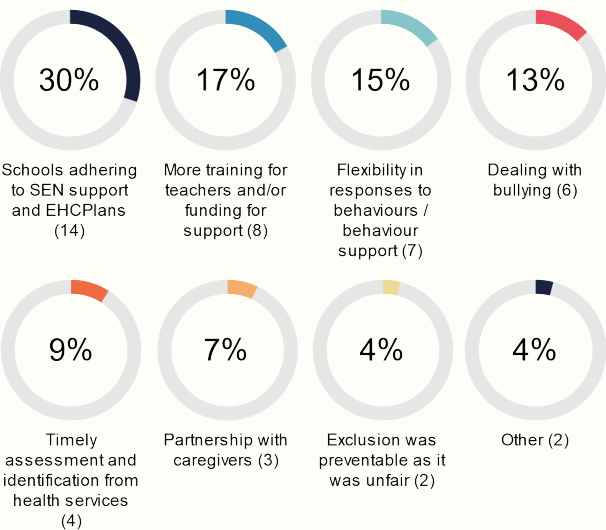
There is a sense that the caregivers felt that the only route to getting support from schools is through gaining a diagnosis from a health professional. Without these plans, adjustments and flexibility in terms of behaviour sanctions would not happen in their child's school. However, for those caregivers whose children had diagnoses, they also reported inadequacies with schools in adhering to both SEN support, EHCPs and medical plans:

- **'The medical report said he needs good support mechanisms or he will experience significant behavioural difficulties and he did'** (no formalised plans)
- **'We were never given a copy of his plan until they excluded him'** (SEN support plan)
- **'Stick by the plans; they haven't got the staff or resources to do it; a lot of it is about resources I think'** (EHCP)

This supports the need for localised training to ensure staff working with children understand their statutory and regulatory duties – that the legal test for an EHCP is that the child ‘may’ have an SEN (Martin-Denham and Watts, 2019). The graduated approach needs to be implemented whenever a child meets the definition of special educational needs, to assess if an SEN support plan or EHCP is required (DfE, 2015a).

The caregivers also highlighted the use of isolation booths as being a contributing factor leading to school exclusion. Their views echo those of health and support professionals, as well as the children who reported they were not listened to or given breaks from the physical space **‘he was in isolation mainly, shoved in a room and not spoken to’** and **‘he’s made to sit and don’t move’**. Comments were also made about restraint and the impact of this being a key factor that led to exclusion **‘you’ve got an eight-year-old child and he is up a height and he is panicked, what is pinning him to the floor going to achieve?’** and **‘he would get upset and end up being restrained and it would escalate constantly, day in and day out’**.

4.9.2. Caregivers’ views on what could have prevented the school exclusion(s): Key stage 4



The views of the KS4 caregivers were similar in some respects to those reported by KS1-3 with the only new themes being schools need to deal with bullying and the view that the exclusion was unfair. The main preventative factor cited by the caregivers to prevent school exclusion was for schools to adhere to SEN and EHC Plans. Some described that when plans were put in place for their child, they were not implemented or adhered to a view shared by some caregivers with children in KS1-3. Similarly, they believed this was the case even when there were reports from other professionals clarifying the child’s specific needs **‘they just said he’s badly behaved, he doesn’t listen, he’s not engaged. He doesn’t follow instructions. I was saying ‘he struggles with the work’, this is his Ed psych report’**.

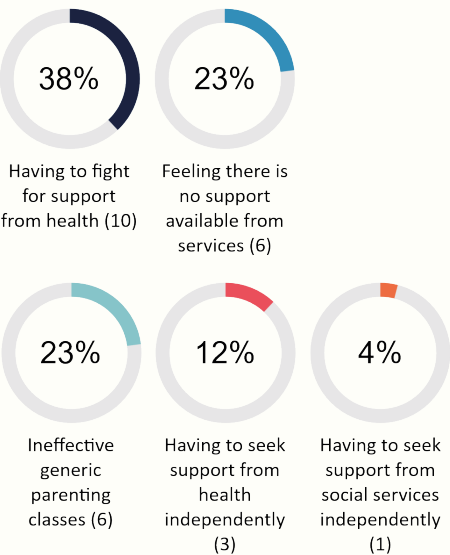
In the analysis, a proportion of the caregivers raised that once a plan was agreed, not all teachers seemed to be aware that it was in place. Or, if they did know, the perception was that they did not follow it and this led to an escalation in the child’s behaviours. An example one caregiver gave was an agreement with the school that if their child was asked to leave the classroom, no other teachers were to engage with him until he self-regulated. However, she felt this was not followed through. Similarly, another caregiver said it was agreed with her that her child would be given a cold drink to cool down as an approach to support them to regulate, but in her view, this was never offered. Others reported incidents where teachers responded to behaviours in a way that would further distress the child **‘there was a plan for them not to get in his face. I was at work. So my son came in and he was bright red in the face and his arms were bright red. I said ‘what’s wrong?’ and he said ‘ a teacher pinned me down and ripped my blazer off me.’ ‘Why?’ ‘because I had a fag in my pocket’**.

It is evident that by KS4, the caregivers are more aware of what should be in place in terms of reasonable adjustments for their Child; they understand the system. This is less evident in the data from the caregivers in KS1-3. As with KS1-3, the caregivers identify training as an issue, to enable teachers to understand the underlying reasons for the behaviours.

‘the answer is to exclude him. Not to get to the bottom of what was the root cause of the anger and the outbursts’.

4.10. Caregivers’ views on the level of support available from health services: Key stage 1, 2 and 3

All 16 caregivers commented on the support available from local services, generating 26 references.



Caregivers used the recurring term ‘fight’ when they described their attempts at accessing timely support from health services. Their perception was that they had to be persistent to get a referral and subsequent appointments from some health services (not paediatrics). Many caregivers described how they felt this was unfair, noting that not everyone would have the skills to navigate the range of services they needed to access for their child.

‘Most parents won’t have the ability to fight; they won’t be able to adequately express themselves to do it or may feel that they can’t, and for a parent to put themselves through that is a really difficult thing. But no one else will do it. There is no one standing at the sidelines within a body somewhere, saying this is wrong’. These children are being marginalised and treated in a way that is shoddy and unlawful, and there is no one stopping it from happening and at some point,

somebody has to stop it from happening, and it can’t be the parents; can’t always be the parents because they can’t do it’.

Some caregivers acknowledged that health services were underfunded and that this impacted on the level of service **‘they are underfunded and under-resourced in my view. You know there are thousands of kids, thousands of kids, in Sunderland’**. There was a sense that they were at a loss of where to go for support due to the demands on health services and long waiting times for appointments. They described the impact of this on children and families:

‘CAMHS is saying its twelve weeks, CYPS is saying go away, Autism Outreach team were massively stretched and the school have got rid of him and where did I go from there? I think the vast majority of the parents would say ‘I don’t know, I’ve no idea’ and they wouldn’t have the resources to figure it out in a lot of cases and that’s the shame of it. There’s no support for the children and there’s insufficient support for the parents in figuring out where you go from there and if the school aren’t engaged and aren’t interested, then they’re on a hiding to nothing, really’.

Equally, some caregivers felt there was no available support from some health and support services and many also stated that the parenting classes they attended through CAMHS were not specialist enough. They felt that these classes were too generic and needed to relate more to children’s individual needs.

Many caregivers also described how they perceived that they were blamed for their child’s behaviour(s) by some health services (not paediatrics or CYPS). They felt they were going through a stressful time and this compounded their feelings of failure.

‘The health visitor said that my child hit me probably because of me, so I thought it was my fault. I know it wasn’t me now she has [a diagnosis of] autism.’

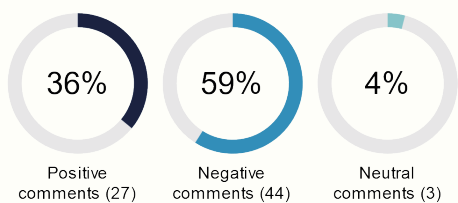
‘They said that her behaviours she displayed were our fault because we weren’t managing her properly, rather than it being an underlying problem that she had.’

‘I think they believed it was me and my husband. That’s how it makes you feel, that the fingers are being pointed at you... Not being funny but when you have a child with severe difficulties, I probably knew more than the person presenting it. That’s just the nature of the child with ADHD and ODD. Also, I had one compliant child that excelled and one with these difficulties.’

‘We tried to get a diagnosis but couldn’t. We were told it was our parenting and we weren’t firm enough. We were sent on classes but they didn’t really help.’

‘We just felt it was just doing something wrong. If you fed back in a parenting class something you have tried, they would say you shouldn’t do that we don’t understand why you would do that; you should do it like this. There weren’t more than ten in the class. It was a very general class, general stuff; they try to cover everything. We would talk about things we have tried. We just used to go back and it didn’t work and they say we haven’t tried hard enough and we are doing it wrong.’

4.11. Caregivers’ views on the enablers and barriers to health and support services



This section examines the enablers and barriers to health and support services, as identified as an emerging theme in the interviews across

participant groups. All 20 caregivers spoke about the support they received. They made 74 comments in total; 27 were positive, 44 were negative and three were general or neutral.

4.11.1. Caregivers’ views on the enablers and barriers to health and support services: Key stage 1, 2 and 3

The paediatric service was viewed to be a strength by the vast majority of the caregivers who were interviewed:

‘It was about two weeks for the paediatrician. We got a diagnosis straight away... they also took blood tests and arranged the speech and language therapist, but they knew my child was on the spectrum. The paediatrician wrote a letter so we could get support and a place for her with school; this really helped’ and ‘they even come to the school, the paediatrician pushed for our daughter to stay at the mainstream school. They agreed that support should be provided there so that she could continue.’

However, one caregiver described having difficulty getting a paediatrician to acknowledge the need for their child to be assessed:

‘I saw a paediatrician, [my child] was anxious, so he was throwing stuff about the room because he knew we were talking about him. The paediatrician said ‘normal, ignore it’. I said ‘you know, it’s got to the point where I can’t ignore it anymore; he’s going to throw a chair off my head.’ So my mum took him out of the room so I could speak to them one-on-one about him. It was agreed he did need further assessment in three months’.

One caregiver described a positive experience with a consultant from out of the area ‘**we have to visit five different doctors, if they do advise anything about her care, they also let the mainstream school know**’. Within the area, a caregiver valued the work of a psychologist from social services in Sunderland ‘**they were quite good. We’re keeping going with that**’.

The caregivers described that if they can get an appointment with CYPS, they generally have a positive experience **‘when you actually get into the system. They are great. I have to say. CYPS are brill. They are the most helpful professionals who work alongside children with ADHD and other issues’**. The issues seem to be when they access one health professional to then be told they need to be seen by a different service:

‘After one assessment, CYPS referred him back to the paediatrician from everything I’ve said, so they said they didn’t think it was ADHD but that it was ASD which has got to be diagnosed by the paediatricians. It took us six weeks to get seen. The worker that we had seen at CYPS was lovely. They emailed through to the paediatrician they had obviously said he was a matter of urgency, so CYPS did massively help him’.

The caregivers also reported what they perceived to be excessive wait times **‘I’m thinking of the CYPS and that’s taken like a year’** and caregivers feel they have to fight for the appointment **‘we pushed for CYPS and for his psychological review to be brought forward. It was good but you’ve got to push them. That’s the hardest bit, you’ve got to push them to get seen, re-tracked’**.

The caregivers’ views illustrate the need for a triage service in Sunderland to provide early identification and/or to support children across the age phase 0-25 years. This would ensure that a health professional can decide which pathway is most suitable for the child (paediatric disability service, community CAMHS or CYPS).

Some caregivers discussed how their child would be discharged from key health services if they were unable to engage during their first appointment (not in the case of paediatrics). The reasons the caregivers gave for their child not speaking were: due to being nervous around new people and anxiety around discussing the difficulties they were having at home and school. One caregiver felt there was no acknowledgement that the child may need more time to become familiar with the staff. A few also described how, following the discharge

for their child not talking, their difficulties continued and they had to be ‘re-referred’ by a GP and rejoin the waiting list, even when the need to be seen was reinforced by a paediatrician **‘the paediatrician was saying that we need to look into this (through CYPS). So I said ‘he is not waiting again. He is just not. He has already been in the system for permanent exclusions and managed move.’ So he went back in then... it has been intermittent because he won’t engage’**.

The findings consistently suggest that caregivers encountered barriers to referrals from their General Practitioner (GP). Three comments alluded to negative experiences with GPs, all relating to a reluctance to refer to another health professional **‘the GP weren’t going to refer us, they thought there were nothing the matter with him’** and **‘we had to really fight for it. It took a long time, we kept getting turned away from the GP. We took an educational psychologist report from the nursery. We took the report to the GP about three times but they wouldn’t look at it’**.

This correlates with the views shared of their experiences of the health visiting team, where the caregiver’s view is not always believed to be right **‘I told them she hit me with force and she was aggressive. They said that was probably because of me, so I thought it was my fault. I know it wasn’t me now she had [a diagnosis of] autism’** and **‘I told them, but nothing came of it’**. This indicates that some caregivers are encountering barriers to accessing support and having their concerns taken seriously.

Two caregivers reported positive experiences of CAMHS, saying **‘they were great but it was more like playful, but they were there for you’** and **‘it was quite quick with CAMHS. I rang the doctors with the way he was going on and said I needed some help. I think it was in about eight weeks that I had my first appointment and I spent nearly a year with them’**. The main issues identified by the caregivers were: children being discharged, having to go to CAMHS before you can go to CYPS, not being seen due to their age, or status of the child, as illustrated in the following comment:

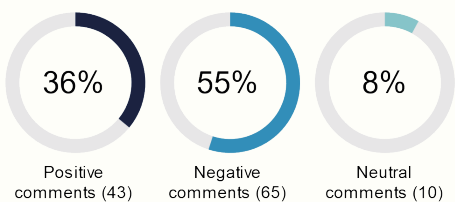
‘CAMHS had him first. You can’t get into CYPS without being referred from CAMHS and you don’t just get that, it’s not automatic. They kept saying ‘oh no, he’s too young’, he was 5. But I said that he’s been suspended from school. I could see all of this behaviour. I wondered, is this ADHD or Autism? But they kept knocking him back, saying he’s too young, to go away. By the time he was eight, things were really bad. Finally, they decided to refer because I kept on going back and I kept going to my GP and said he’s been suspended again, so they referred him to CAMHS. Then we had to wait ages for an appointment with them and then eventually we got referred to CYPS. You’re talking four years, four and a half years. It’s terrible, really. When I was crying on my knees for help’.

This is one of the main issues arising from the interviews, that the families and children in Sunderland don’t always have a route to support. CYPS do not appear to be assessing children under the age of six if there are any indicators of ADHD, and age nine for ASD. However, the CYPS website suggests the service is for children from 0-18 years, who are experiencing psychological distress or mental health difficulty. Children with emotional and behavioural needs can get general advice from the paediatric disability team, who can also exclude physical health conditions. The children need specialist assessment for ADHD and ASD, and other neurodevelopmental needs. It needs to be considered if CYPS could reduce age limits, more in line with early intervention and the graduated response (DfE, 2015a).

The caregivers felt that CAMHS could be improved if they observed the child in their school environment, if that is where the concerns were. Some caregivers did say a CAMHS worker had gone to school but this seemed to be inconsistent. Again, children are discharged if they are not willing to engage; the caregivers felt that it would take their child some time to open up to professionals, given their difficulties but this is not possible within the service. An alternative approach could be to change the practitioner to see if they are able to form a relationship with the child. It is also the case that for these children, they will then be

relying on schools for support, which is unlikely to be within their expertise.

4.11.2. Caregivers’ views on the enablers and barriers to health and support services: Key stage 4



All 21 caregivers spoke about the support they received. They made 108 comments in total; 43 positive, 65 negative and ten general or neutral comments.

Similar to the caregivers’ views with children in KS1-3, the paediatric disability service was identified as a strength, as were educational psychologists. Again, there are caregivers who perceived they did not get any support from health services **‘we’ve had doors shut for years. We’ve had loads. I’ve lost count. None have helped. We’ve had no full assessments; this is despite school exclusions and requests for support’** and **‘what do you want me to do?’ We said ‘well, he is shutting down, why? Is there a reason behind it?’ The GP said ‘You are just clutching at straws’**. All the comments for this age phase were negative regarding support from health visitors, as either nothing was ‘picked up’ or nothing happened to follow up concerns expressed by the caregivers.

Similarly, the descriptions from caregivers for this age phase relating to their experience of CYPS were more negative than positive. The positive experiences related to being seen in a timely manner when children presented with extreme behaviours such as attempting to take their own life. Positive experiences also related to support plans for use in schools and the identification of neurodiverse needs such as ADHD, dyslexia and post-traumatic stress disorder (PTSD). The negative aspects of CYPS included caregivers feeling that there was a lack of support when a child is in crisis, with limited access to an out of hours service; lengthy waiting times of up to a year, and the time it takes to receive a diagnosis (years in many cases); and staff in the service being off work, meaning changes in workers or cancelled appointments. It seems that the caregivers see the securing of a label for their child as necessary if they are to access support in school. It is understandable that caregivers are driven to secure a diagnosis.

In relation to CAMHS, it became evident that there were more negative than positive experiences. The positives identified were: assessments taking place in the school environment and the knowledge of the team **‘they said ‘I believe that he has ADHD’. And I said ‘he hasn’t; he’s not hyper. But they explained it to me. He’s at CAMHS still because he is on ADHD medication’.**

The main issue described by the caregivers was long waiting times and a feeling that they are discharged too soon **‘he only had one initial meeting and the school decided it hadn’t worked for him. But we had only just gotten for the first interview, where you just say what the issues are and then you decide to set up appointments. So to say that comes hadn’t worked, it hadn’t even been given the chance to work’.** Some caregivers reported that they are on the ‘overtime list’, their perception of this is that they are only seen if there is overtime available and their child can be ‘fitted in’. This was echoed by other caregivers, saying a worker said ‘I am just working overflow’. The caregivers reported that they feel their child doesn’t matter as much as children on the main lists. A key challenge cited by caregivers

is the CAMHS ‘exemption list’ or ‘special circumstances’, which means some children are unable to be seen and have to wait for a CYPS appointment. The list includes children:

1. Who have learning disabilities
2. Who are, or have been looked after or accommodated, including those who have been adopted
3. Who have been neglected or abused or are part of a child protection plan
4. Who has a learning or physical disability
5. Who have a chronic, enduring or life-limiting illness
6. Who have substance misuse issues
7. Who are at risk of, or have been involved in offending
8. Who are homeless or who are from families who are homeless
9. Whose parents have problems including domestic violence, illness, dependency or addiction
10. Who are placed out of the area
11. Who are placed in a secure placement
12. Whose parents are in prison
13. Who are from a minority ethnic or minority cultural background including travellers
14. Who are not involved in education, employment or training

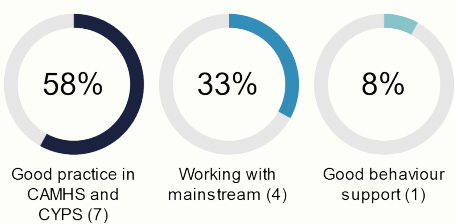
The result of these special circumstances is that caregivers felt there were too many barriers to accessing CAMHS **‘as it was out of CAMHS threshold then we had to be referred to CYPS, that was another twelve-month wait’** and **‘they wouldn’t deal with us because of my son’s father’s status’.** This research highlights that it is imperative that the special circumstances list is withdrawn to allow the securing of support earlier for children who are unable to wait for other service appointments. Education Policy Institute research continues to identify eligibility criteria as the main reason specialist mental health provisions reject referrals into service, often citing the necessity of high thresholds due to capacity (Frith, 2017). The caregivers’ views show that the impact of prolonged waiting times is that their child’s difficulties escalate. During this time, without accessing the specialist support, children and young people’s mental health may deteriorate (CQC, 2017), impacting their education.

4.12. Health and support professionals' views on the health and support services

This section represents the data collated from professional cohorts on the existing Health and Mental Health provision within Sunderland.

4.12.1. Views of health and support professionals: The positives of health and support services

Of the nine health and support professionals interviewed, five reported positive aspects of services, generating 12 comments.



Good practice was reported in both CAMHS and CYPS relating to signposting between the services to ensure the child is referred to the most appropriate organisation

‘There is a path between us two. If a parent refers to them on the phone, a phone consultation, they will signpost it back to us. So if it goes to the wrong place it doesn’t matter. We have a formal manager meeting once a week and stuff gets passed. So things get filtered in. If a referral comes in with the mum being bipolar, then that immediately goes to CYPS, even if it comes in on our referral’.

and

‘The referral system is effective in one sense; there is a dialogue between CYPS and the Tier 2 service. Referrals can come through all of these means. They do get triaged by our managers on a daily basis. We have an on-call system here for the clinical leads. So we do triage and if any other service can provide a quicker response and a meaningful response, then we do signpost those, for example, if counselling is

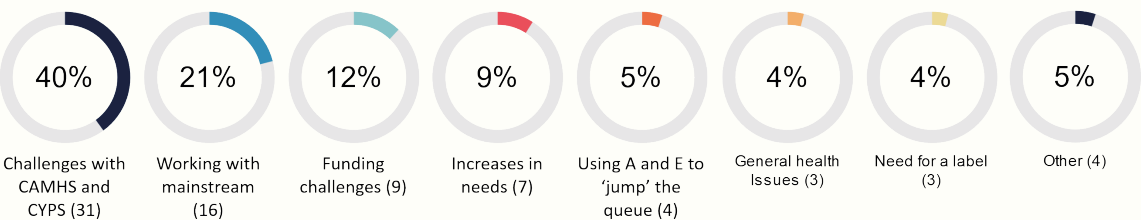
needed they could get that from MIND. If they are 16-17 there is the ‘I am’ service’.

It was evident that the health organisations do not want children waiting on lists for support. The exemptions list in CAMHS means that some children are automatically filtered out of their service **‘every week we have a meeting and we take some referrals there and thrash it out, with the special circumstances ‘Which can you work with? Which can you not?’ It’s like, we do try’.** This echoes the concerns of the caregivers around the threshold to be seen by the CAMHS service. An approach to reducing wait times in one service was by employing **‘lower banded people to do low-level interventions, almost off-the-shelf’.** It was reported that these practitioners support children with low-level anxiety **‘it lasts 6 weeks and for some families that is enough. It has massively impacted on the waiting list. Because those 7 people, even if they see one a week, that is seven off our list’.**

Health and support services had four positive comments regarding working with mainstream schools. One comment was that **‘my experience of schools generally is that they will try everything within their remit and their resources to try and accommodate young people’.** Two comments specifically commended some mainstream schools for their support of children with looked after status **‘more schools do take into account the looked after status. The headteachers have been in receipt of training’ and ‘there are some attachment-friendly schools and I think there are those schools who really embrace the social-emotional aspect of learning’.** A final comment commended one school’s reasonable adjustments for a child with multi-faceted needs **‘a little girl, where the school has been amazing at making reasonable adjustments. This little girl with primarily a physically disabling condition and a movement disorder but she’s also on the autism spectrum, she’s typical intellectual ability and the school have really bent over backwards to accommodate and make adjustments for her’.**

4.12.2. Views of health and support professionals: The challenges with health and support services

All nine health and support professionals shared their opinion of the issues with services, creating 77 comments



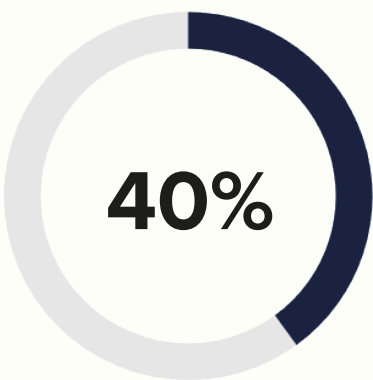
Challenges within CAMHS and CYPS

The perceived challenges within CAMHS and CYPS was the dominant sub-theme shared by health and support professionals. Due to the size, it has been broken down below.

Challenges with CAMHS and CYPS: Pathways to support

Unclear pathways to different services

Five of the comments were explicit that there was confusion about the different pathways for children of different ages who had different types of needs. These views echoed those of some of the caregivers (4.11.1), that there is not always a clear route to support. A health professional agreed feeling that this led to most people sending referrals to paediatrics **‘but there is a limit to what paediatricians can do. As I said at the outset, I think there are major capacity issues with CYPS’**. Another reported that CAMHS are unable to work with children as soon as they have a diagnosis **‘as soon as they do, it’s CYPS’**. One participant was unclear of which pathway to follow, as referrals had been rejected. These views support the findings of the Department of Health and the NHS England Task Force (2015), that there is a fragmentation and lack of cohesion nationally, resulting in children falling between the gaps in service provision which can lead to multiple referrals to get to the right service (Iskra et al., 2015). The impact of confusion around which service is best able to meet a child’s needs was raised by National Association of Headteachers (2018), that schools need to know the support available to ensure effective mental health support is gained.



Challenges within CAMHS and CYPS (31)

Another question was raised around the appropriateness of all caregivers following a parenting programme **‘regardless of if they get a diagnosis or not, that the first intervention should be parenting’**. This correlates with the views of some key stage 1-3 caregivers, who reported that the parenting classes they attended through CAMHS were, at times, too generic.

Exemption list CAMHS

The five comments intimated that the current exemption list in CAMHS means that many children who would benefit from the service are unable to access it **‘the special circumstances involve a lot of different factors...The exclusion list is a barrier’** and **‘I guess CAMHS are little more, I’m being careful what I say, but are a little more flexible about the special circumstances. Because it is possible that a young person with a diagnosis of Asthma is still able to benefit from a counselling intervention’**. The other views expressed proposed that the exemption list needs reviewing, as some of the historic needs of the children were low level but the checklist limits access to support **‘so it is a tick box. Is there Domestic Violence? Is there a diagnosis? Is there a mental health need diagnosed in a parent? Are they LAC? All of those are special circumstances, even if they are quite low level’**. One participant suggested that some teachers had been driven to lying about a child’s history, so that they would be seen by CAMHS. This is an issue as the CAMHS staff then check with caregivers and they don’t meet the threshold to access the service **‘we identify at initial assessment that they need to go to CYPS. So they go to the bottom of CYPS list. It’s wait, wait, then wait’**. The exemption list could result in caregivers being unclear as to where to go to seek support, as found by Iskra et al. (2015).

No pathway available

Four participants in health and support services claimed that there are challenges with the current pathways to support within the different health services. These were as follows:

- ‘There is no pathway for 3-6-year-olds with challenging behaviours. Some have behaviours that stem from learning difficulties, Autism, ADHD and from genetics but the early years needs a better service’.
- ‘Sometimes we get referrals for younger children. The paediatric person we work with, the neurodisability consultant, they don’t do ADHD assessments but they do ASD assessments ‘til the age of 9. If they get some referrals like that, underage, we will pass those over to them. After that, we triage them and get them on the waiting list’.
- ‘Sunderland is joined with South Tyneside but we have different processes, which isn’t working. South Tyne will only assess their children for Autism at the age of 5, whereas we do this for 0-9 years’.
- ‘CAMHS won’t see children for ADHD until they are 6 years old. This is unhelpful as I see in clinic children who are clearly showing indicators of ADHD but there is no pathway for them; it doesn’t work. The fact is, they have needs and should be seen’.

These comments support the claims of the caregivers (4.9.1), that they felt they encountered barriers to gaining access to appointments with health professionals and being turned away from GPs; being told to return when their child was older.

Transition to adult services

There was a sense from the comments from three health and support staff participants that there could be improvements in relation to the transition between child and adult mental health services **‘we don’t get many but I can think of young people who it was appropriate to go to adult services. But I can think of one young person, who was nearly 18, who wasn’t ready for adult services’** Another felt there was an issue for those who turn 18 halfway through support **‘I had to refer. Because on your 18th birthday is your cut off for CAMHS, which is too rigid. If they were with us and turned 18 and I was halfway through then we would finish it. But we couldn’t then refer to CYPS. Because CYPS would just refer to adult services’**. The other participant would refer 17 year olds to adult services due to wait times **‘I’ve had a number of young people who I have done CBT with who are about 17. They may need an additional service. We know they will wait around 9 months. It’s longer for ADHD or ASD pathways. We know they would be nearly 18 so we decide with the young person to just refer to the adult service’**.

Challenges with CAMHS and CYPS: Waiting times for appointments

Three participants shared concerns regarding wait times for both CAMHS and CYPS appointments. One reported **‘it is a big concern, it is a big wait, which is a concern and is no good for families. Early and timely identification of each and every need is what we ought to be delivering. CYPS and CAMHS ought to be held to account’**. Another commented on how the wait times affect the progress of an EHCP assessment **‘CAMHS and CYPS are not meeting waiting times and the impact of this is, for an EHC assessment, there is not a full picture of each and every need, as they cannot be seen in the 20 weeks, so the EHC is based on when I have seen them.’** The final comment agreed with this, adding that there is a high percentage of children who are excluded from school awaiting an appointment with CAMHS or CYPS **‘mainly it is continuous disruptive behaviour. And with**

those, they either clearly have a diagnosis of ADHD or ASD or something like that. Or they are going through the assessment or waiting to get assessment’. Three participants felt that the main service with long wait times for appointments was CYPS. In two cases, the wait was nine months and in another case it was a year. A further two comments suggested that the wait time for CAMHS was also too long **‘I wouldn’t agree with a 2 to 3-week wait for CAMHS. I know of children who are at least 3 months for either service’**. These views echo those shared by some of the key stage 1-4 caregivers, that they felt they had to fight to access a CYPS or CAMHS referral, raising that not all caregivers would feel equipped to persist (sections 4.10; 4.11.2). However it is important to acknowledge that the greater demand on mental health services continues to increase, compounding demand on other local services (Roa et al., 2010; Bone et al., 2015; Crenna-Jennings and Hutchinson, 2018).

Working with mainstream

Health and support professionals noted that some mainstream schools were extremely good at meeting the needs of children, whereas others were less so, in relation to applying reasonable adjustments before and after a diagnosis.

‘Reasonable adjustments should be based on needs and I put this in my letters all the time. That doesn’t always happen, but some schools are absolutely fantastic. You can name which schools embrace disability better than others and in some schools, your heart sinks and they come to the clinic and you realise what school they are in because you just know the adjustments aren’t going to be good enough.’

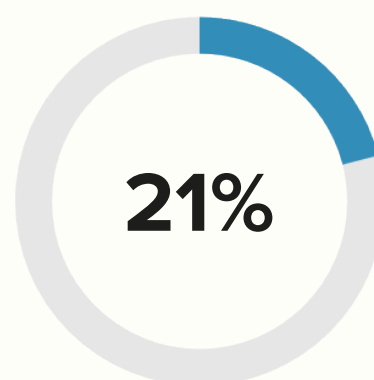
‘When I write back to SENCOs I say ‘Please make adjustments now based on this’. This family has come along to me to say that SENCO said we can’t do anything until we have a diagnosis’ and I turn that back and say ‘no the school should be doing what they need to do based on the needs instead of waiting for labels.’

These comments correlate with those made by the key stage 4 caregivers (sections 4.7.2; 4.9.1; 4.9.2), who shared that it is imperative that all teachers understand the impact of diagnosed needs on children’s behaviour and that reasonable adjustments are consistently applied by all schools where a child has a recognised disability.

Some participants also felt that some education colleagues did not recognise a child’s behaviour in school **‘sometimes I’ll have to try and convince them... they just see it perhaps as a behavioural issue’** and **‘the greatest sadness for me is that it’s not always recognised it’s just somebody being really badly behaved. You’ve got to really peel back the layers.’** One participant went on to suggest the system as a whole was not good enough at identifying need and this was evidenced in school exclusions **‘it breaks my heart when children and young people are excluded from settings because of symptoms which are usually behaviours. It is because of system failure because we haven’t identified each and every need. We haven’t put the right adjustments in place and we haven’t supported the family.’**

Further comments from health and support professionals note how the accuracy of data collected in some schools did not reflect the actual levels of need in children, and this had knock-on effects particularly around transition points in education.

‘Unfortunately, a lot of our schools, I was only doing data last night, actually only identify that they may have a need and they will identify what that primary need may be. However, they don’t actually tick the box that says they have a SEN need, so



Working with mainstream (16)

the data that goes off to official people will say they don't have a SEN need. [...] I think there are some hidden needs of children that are not being identified in some of the statistical data. I know that because if I asked them for plans for an Alternative Provision, they might write ASD on there, but they haven't ticked that box on SIMS, our data system.'

'I have gone to the permanently excluded meeting; normally parents do ask me to go with them. I have sat and questioned myself: 'Can I ask what was that child's SEN status when they were in primary?' They've said it was down as SEMH; I've said 'So what was the transition plan when that child came in?' They will say a little bit but then they will say his academic data didn't show me that'. They will look at the academic data and say 'this child is achieving level 4 and 5'. They get the levels they're supposed to get but in the background, it says this child may have a need. So when they get put in a completely different environment, they may have that data but they fail because they are not given that nurturing support.'

Participants acknowledged the challenges schools face and the impact of limited resources.

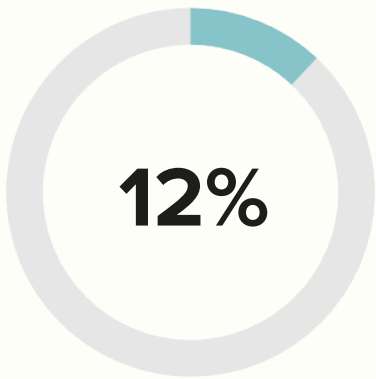
'Previously, children with special needs would have had additional support, a lot more flexibility from staff; a bit more time, a bit more explanation, then they can cope. That is also limited. And it is the same staff, they all mean well and they do try. But the resources that they have are limited. So then what happens is they are struggling more, they are getting excluded more, they are just not coping.'

Funding challenges within health services

The health and support professionals noted challenges with funding for mental health services. A concern was raised regarding how funding reached front-line services 'I'm not confident that the money that was supposed to filter down to front line services actually has done. So there are long waiting times, still. And the waiting times to some extent are disguised. Because they will offer an initial appointment but then the child is then on a waiting list for a year, or even more than a year, for whatever the further assessment work or intervention is'. This could be indicative of health spending being poorly measured, in particular children's health services, which are more vulnerable to cuts (Children's Commissioner Office, 2018a).

One participant raised concerns regarding the impact of staffing of key mental health services.

'So there may be some issues about vacancies and having enough trained people coming through, but the bottom line is that resources haven't translated into capacity in teams



Funding challenges (9)

to identify each and every need in a timely way. This notion was announced by the government of: every child and young person with a mental health problem being seen within four weeks. Oh my goodness, we are light years away from that being achieved. But if that was achieved, it would be transformed and it would make my job a lot easier because I am the sticking plaster for families at the minute, because at least I will listen to their issues. I can't diagnose the mental health conditions but I can be an advocate for them. But I get fed up of continually writing letters that are rejected to mental health services and I find that really frustrating. The families find it really frustrating'.

This view was endorsed by other participants who further acknowledged that lack of funding for transforming children and young people's mental health was a national issue. It has not filtered down to improve the capacity of services, so services **'just don't have the capacity'** and **'there is only me, how can I possibly treat everyone'**. It was also raised that due to a lack of funding in mental health services **'they can only offer 10 sessions because of funding? The way it is commissioned is ridiculous from our point of view. The workers on the grounds here say that. I'm sure that CYPS would say that as well'**. A view was also shared that funding was needed for therapy **'some children need more therapy. And that is where the gap is. In the therapeutic support that children need.'** A final point raised by two participants was a perceived demise in services impacting on families. Some of the caregivers themselves acknowledged that health services were underfunded and that this impacted on the level of service, meaning they did not know where to go for support (4.10).

P1: 'So in the past, we had things like Sure Start Activity Centres and all of those things. And now mostly they have gone.

P2: Yes, definitely. I think that parents really have nowhere to turn. They come to me and I can only...this service is billed as the saviour which it completely isn't. I don't think there is much, outside Autism Outreach, who are great, but they are massively worked off their feet. [...] Then there is a massive waiting list for CAMHS and CYPS. Two years ago I was approached by somebody who does private work, Mental Health work [...] I didn't believe that people should be in this position, for it to cost thousands of pounds when it should be free at the point of delivery. I think there is not much help out there and what is there is rationed. And if you want to go privately, or if you want something extra, people can't afford it. Certainly not in Sunderland'.

Increase in needs

The views expressed by the health and support professionals suggest that there has been a notable increase in social, emotional and mental health needs of children over recent years **‘I think self-harm is very common’ and ‘emotional and behavioural difficulties, and request for assessment for that has gone up quite significantly over the years I have been working here... What has gone up is the other things; emotional regulation issues, attachment difficulties, parenting difficulties. Probably they ask the questions, query ADHD or Autism or learning needs, not coping at school, bullying-related emotions, that sort of thing has gone up really high’.** The remaining comment spoke of rising numbers of looked after children.

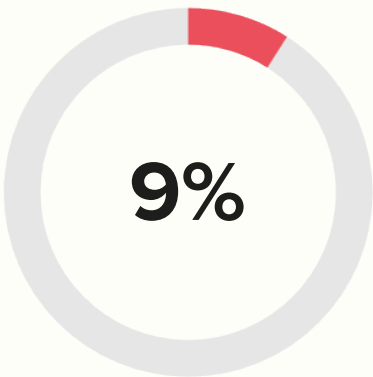
‘Then in Sunderland, we have some LAC facilities. Placements for LAC who can come from out of the area, where they are special closed placements. Those children come with their own challenges. Drugs, offending, sexual exploitation. Those children who are out of parents’ control, there are a few of those facilities in Sunderland. That does increase the demand as well. Not just for those children but for that area; the other children in that area are also affected’.

Using A and E to ‘jump’ the queue

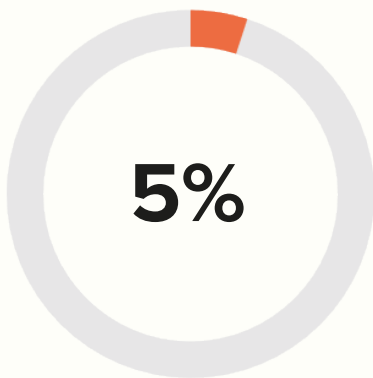
Four of the health and support participants perceived that schools were advising caregivers to take children to accident and emergency departments, as they felt they would be seen sooner than through other referral processes **‘schools are saying just take them to A and E. Someone will see them’ and ‘but those SENCOs, that is the only way they have found to get through the door in a desperate situation’.**

General health issues

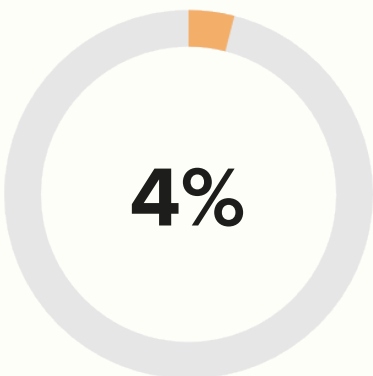
An area of concern raised by health and support professionals regarding health and support services was that they felt it was difficult, at times, to get children to be seen by particular mental health services. One participant perceived that **‘I write to the other services but I get a letter back saying there isn’t enough information to see them. The point is they are meant to assess them, I assess for autism, physical and learning disabilities. CYPs should be seeing children for mental health and neurodevelopment. They are in a silo’.** Another participant said they **‘get fed up of continually writing letters that are rejected to mental health services and I find that really frustrating. The families find it really frustrating’.**



Increase in needs (7)



Using A and E to ‘jump’ the queue (4)



General health issues (3)

One participant suggested that children who are excluded from school should be automatically referred for a paediatric assessment, as should any children entering the behaviour intervention provisions. They added:

‘You know, I remember one girl in the clinic who was on her last day in her nurture group provision and was going back into mainstream the next day. She came to me from community CAMHS and they had been involved, but her autism hadn’t been diagnosed. So I diagnosed her with Autism, but then she was going back into mainstream the next day, so there wasn’t time to get those proactive adjustments in place. So I think we should be assessing children earlier in their journeys, not when the wheels have all dropped off and it’s all too late. It definitely shouldn’t be when the clock started ticking on Education Health and Care Planning. It should be much more proactive’.

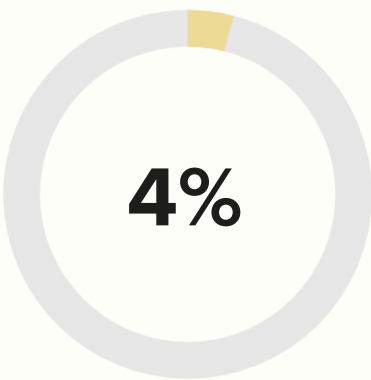
Need for a label

Three health and support professionals shared their concerns about schools needing to have a label of need for a child’s needs. The first participant commented on the importance of diagnosis for some children **‘it is having an impact on their ability to function, they are unable to function without that diagnosis being recognised. Without support.’** There was also concern that labels were needed to access necessary support in schools.

‘If a label is needed, there is pressure from parents and from school, ‘What diagnosis have they got?’ Previously, we could say they have traits of this and traits of that; this is what they will cope with. But that is not enough unless you have a label. Talking about ADHD and ASD traits, we know traits are quite common in the general population of school children. But if you have the capacity to be flexible, you can manage this. You don’t necessarily need a label and the external support; you can manage with the resources that you have. But the resources people have are so stretched, they need to have a label’.

Another participant perceived that the pressure on health services increased due to the pressure of attaining an EHCP.

‘The pressure on our services has gone up significantly with the pressure for EHCPs. Parents will say ‘All through primary’ – ADHD and ASD doesn’t suddenly come on in secondary school, so what was happening? How come they managed in primary? Parents will say it was just brushed under the carpet and we knew all along. Other parents say ‘We knew there was a difference, but they were coping and that is all we want.’ They will have been supported by Primary school; more teacher support, someone else supporting would have been shared out between two or three children. And they were fine. It’s only when they went to secondary school and nothing was offered that they were pushed into the deep end and are not coping’.



Need for a label (3)

4.13. Advisory group of health and education professionals: Challenges, questions and concerns

The ten professionals from education, health and support services were asked to give their views on the emerging themes from the interviews. The main areas identified were to reform key services.

Health recommendations from interviews and advisory group

- A duty SEMH crisis (CYPS) worker to take calls from 8 am until 5 pm to allow for issues arising before, during and after school.
- A review of the age ranges of children CYPS is able to assess to ensure equity with South Tyneside. CYPS won't see children under six for ADHD and nine for ASD. There should be a pathway for assessment alongside appropriate physical health investigations including genetics. This, links with caregivers saying the Health Visitor (HV) and GP send them away until the child is six age.
- When a child won't engage with CAMHS or CYPS practitioner, rather than discharge them, alternative approaches should be sought. For example, a change in staffing or
- appointments within the school and/or familiar home environment.
- To explore the possibility of a mental health nurse practitioner or other approaches, to work across a range of schools where there is a high level of need.
- Remove the inequitable special circumstances list in the CAMHS referral system, as this results in some children not being seen. There are long wait times for CYPS, affecting the availability of timely support. This is at odds with the system in South Tyneside, which sees all children.
- Review the impact and suitability of generic parenting courses. The findings suggest that these are not suitable for supporting families with children who are neurodiverse.

Other health services

- To reduce wait times for ASD and SaLT teams to send reports to consultant paediatricians. Increase capacity for ADHD assessments to be carried out by training learning support or health care assistants (does not need to be a doctor).
- Good practice guidance to be circulated to GPs and HV team on when to refer to other health professionals; quality principles for paediatric disability services.

Community support

- Volunteering programmes so that experienced caregivers mentor those less experienced with parenting, e.g. in cooking and participating in locally provided events such as sports,
- To inform schools of the benefits of youth workers and community organisations to work alongside schools supporting children and young people. This will include sharing the work and opportunities through Sunderland All Together.

5. Concluding Remarks

5. Concluding Remarks

The first objective of this research, 'to elicit the perceptions and experiences of excluded children, their caregivers and professionals of the barriers and enablers to mainstream schooling', has been achieved. The second objective was to 'to determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream school'. The evidence suggests that, for many reasons, these children struggled to cope in a mainstream school environment. There will need to be a shift in the values and ethos of some stakeholders involved in their education and care. These are described in greater detail in the main body of the conclusion. The final objective was 'to evaluate the effectiveness of national policy in supporting children to remain in mainstream school'. The main red flag highlighted by this piece of research relates to the vague national guidance on the use of isolation booths within schools. Until this issue is addressed in policy, schools will continue to isolate children without sufficient constraints, placing them in situations similar to those reported in this research. It could be argued that placing a child in isolation for any length of time would fall under the NSPCC (2019) definitions of emotional neglect: 'the child doesn't get the nurture and stimulation they need. This could be through ignoring, humiliating, intimidating or isolating them', and emotional abuse: 'continual emotional mistreatment of a child, which can involve deliberately trying to scare, humiliate, isolate or ignore a child'. There also needs to be an investment to ensure children at risk of exclusion have the most appropriate academic and/or vocational model/ curriculum, teaching approaches and class sizes to develop and learn to their full potential. It has been a privilege to have had the opportunity to hear the voices of the children, their caregivers and the professionals who provide their education and care. They have all provided useful intelligence for TfC to shape services, provision and training across the City. Through the interviews and subsequent analysis, it is evident that there were multiple factors over time that led to the children no longer being

able to continue their mainstream education alongside their peers. This section shares the circumstances and policies that would have likely contributed to school exclusion and highlights what could be done to improve mainstream schooling.

The importance of creating and sustaining relationships

One of the main findings in this research is that children thrive where there are positive relationships with teachers and peers, where they are listened to and supported with learning. The research validates how these positive connections create a sense of belonging and act as a protective factor, supporting children to remain in mainstream provision. It is also evident that some children do not feel they belong and this is reinforced by their caregivers, who felt their children were victimised by other children, and at times teachers, because of their differences or challenges with meeting behaviour expectations. There will be many schools who have supportive and nurturing environments, who promote acceptance within and outside their school communities. The current secondary education model of multiple teachers across a school day seems to be detrimental to those children at risk of school exclusion. An alternative model, perhaps based on the structure of primary education, should be explored, so that the likelihood of building positive and sustainable relationships is increased.

Curriculum issues

As schooling becomes more formalised in KS1, the obstacles to participation and engagement are increasingly evident for some children, as the curriculum moves from play-based approaches in the early years to the national curriculum. Schools should be promoting academic and vocational excellence through high aspirations and quality teaching, but this needs to be balanced with safe and nurturing environments so children can become purposeful and healthy children and adults.

This research shows that as children move through school, their enjoyment of learning diminishes as the child-centred approaches and opportunities for play and creative approaches to learning decrease. From as early as KS1, many children knew they were unable to access the academic level and volume of school work. This reinforces prior research that has identified that young children are more anxious and stressed about school work than in previous years. It is likely this is due to accountability measures on teachers and an ever-demanding curriculum that does not take into account the multi-faceted needs and abilities of children. The caregivers echoed the views of the children that they are unable to meet the academic demands expected of them, reinforcing the idea of exploring alternative routes. The concern is that the expectation on children to attain is the same, regardless of any underlying difficulties they may have with mental health, learning needs or experiences of childhood adversity.

This research supports the need for alternative curriculum models for children for whom an academic route is not desired nor appropriate to their strengths, interests and diverse needs. The current academic pathway, particularly in secondary education, is not relevant to the wishes and aspirations of many of the children who participated in this research. There needs to be a move away from studying multiple GCSE subjects when a vocational route is more suited to, realistic, and importantly, requested by the child.

Classroom issues/reasonable adjustments

The youngest children in this study felt that teachers were the main source of support within the school but this view changes drastically by the time the children reach KS4. Schools have a legal obligation under section 21 of the Children and Families Act, 2014 to ensure that planning for learning is differentiated and personalised to meet the individual needs of children. Schools are in an impossible position of having to meet the varying needs of children, with large class sizes, limited resources, limited staffing and evidence-informed training. Additional funding

for schools is needed if teachers are to be enabled to provide the level of support needed to secure learning and maintain self-belief in those children who have barriers to learning. The children and caregivers across the key stages have shared that lessons are not accessible due to learning and mental health needs, this results in a downward spiral of low self-worth affecting children's ability to participate and learn and to conform to high expectations of behaviour.

Responses to behaviour

The caregivers alluded to the feeling that schools did not understand their child's needs and that their behaviours in school were due to their needs not being met. They suggested increased flexibility in behavioural policies, and behaviour support in mainstream schools is necessary to prevent school exclusion, a view supported by the children. There also needs to be an in-depth understanding of the reasons for children's behaviour(s). The children themselves say they wanted to talk to teachers and for teachers to listen to them. Therefore schools need to invest in giving children the earliest opportunity to talk about their views on school and their barriers to education. In addition, a review of training should be carried out to better prepare teachers across key stages in providing evidence-based approaches to support children instead of, in the opinions of children and caregivers upholding inflexible and unrealistic behavioural policies.

The use of isolation booths

This research has highlighted the widespread use of isolation booths, particularly in secondary education but also in the primary phase of schooling. Isolation is not monitored locally or nationally and this allows schools to retain children day after day, for months and in some cases years, without education or positive interaction with teachers and peers. For eight of the children interviewed, isolation booths were used as continuous provision, with lengths ranging from one to three years. Based on the accounts from this research, we cannot fully understand the implications of this sanction on children's mental and physical health, and educational outcomes, but the reality is that

this suggests emotional abuse and neglect (NSPCC, 2019). The conversations with children highlight the long-lasting impact of isolation booths on those who had to sit for long periods of their mainstream secondary schooling. Ofsted (2018) confirmed that schools can use isolation for limited periods of time but that it should be lawful, reasonable and proportionate. The evidence in this research suggests some schools are contravening this guidance, as it became apparent in our conversations that some children were placed in isolation for reasons that were seemingly neither reasonable nor proportionate to their actions.

Several children mentioned that they had been sent to isolation for reasons they found hard to understand, such as 'I had just arrived from a managed move' to wearing makeup, the wrong skirt, false tan, not wearing the correct shoes or being late for a lesson. Until the Government provides a directive on the use of isolation booths, schools will be able to continue with this sanction.

It was evident in the interviews with the children that when they were in isolation, it was a solitary experience. For some children in this study, isolation booths became their 'statutory education', as they were not, in the vast majority of cases, spoken to by teachers or taught. The expectation that children will complete work set by teachers without guidance is beyond comprehension and has no regard for their strengths and multi-faceted barriers to learning.

It appears that for some children in this research, the impact of isolation may have long-lasting and detrimental impacts on their mental health, wellbeing, academic attainment and ultimately engagement with school. The children in key stage 2-4 referred to the impact of isolation on their mental health using language such as 'depression', 'coping' and 'loneliness'. This research strengthens the argument that isolation booths do not transform or modify behaviour, as all of the interviewed children who experienced isolation, went on to be permanently excluded from school. Only two secondary headteachers believed isolation would improve behaviour and there was no consensus among SENCOs

on its effectiveness, with one reporting the disproportionate number of children with SEN who end up in isolation.

This is a recipe for resentment, frustration, anger and sullen defiance, and is not a way to persuade a child to engage with others in learning. Overall, the data suggest that for some children there may be an over-reliance on the use of isolation booths in secondary schools and as a result, there is limited or no education for children who are regularly isolated. Both the health and education advisory groups agree there needs to be a shift in school policy around placing children in isolation booths due to the negative impact upon the child's holistic development. Local Authorities have no power to address this with academy schools, only those in the maintained sector. However, this raises serious questions at a local and national level as to why isolation booths are continuing to be advocated as an approach for use in schools.

Health services

This research highlights caregivers' perception of the need to secure a formal diagnosis to gain support from a school in terms of interventions and flexibility in behaviour sanctions. It is understandable therefore, that the caregivers are driven to secure a diagnosis. The impact of this could, in part, explain the high numbers of children within the health services and the compounding impact on resources resulting in lengthy waiting times and frustration for all parties involved. It is clear that the caregivers view health services positively when the appointments are timely and when they are listened to. It seems the challenges with being referred for support begins in the early years, with many caregivers believing they raised concerns at the two-year progress check with health visitors only to be dismissed predominantly as 'bad parents'. It needs to be ensured that caregivers' concerns are taken seriously regardless of the child's age, with signposting to the most appropriate pathway. This research has also indicated a training need for health visitors to ensure there is consistency in how the teams recognise and respond to the caregivers' concern when they share concerns about their child's development. The research

has also highlighted the need for a review of the pathways in health to ensure there is equity in access to services regardless of the child's age or particular needs. This view was shared by caregivers and health and support professionals alike and both suggested that in some instances, there were no obvious pathways available. Professionals also cited the special exemptions list for CAMHS as a challenge in their service area, suggesting it acts as a barrier for children accessing support.

Training

Education providers across all age phases need support and guidance to ensure they access high-quality training across education, health and care, to enable them to meet the diverse needs of children through evidence-based approaches. The advisory groups in this research all emphasise the need for targeted training, beginning with the secondary schools in Sunderland. This must focus on classroom-level practices to support teachers in the use of the graduated approach (DfE, 2015a) and application of their legal duties for children with SEND (Equality Act, 2010; Children and Families Act, 2014).

The main factor cited by the caregivers to prevent school exclusion was for schools to adhere to SEN and EHC plans. Their overwhelming view was that when plans were put in place for their child, they were not followed or implemented properly. This seemed to be the case even when there were reports from other professionals clarifying the child's specific needs. This needs to be accompanied with the dissemination of the pathways to the paediatric disability service, community CAMHS and CYPS, as it appears these are not fully understood by either caregivers or professionals.

Without the commission from TfC, and the views of children, their caregivers and professionals across education and health/support services, it would not have been possible to carry out this research. This research is a starting point in capturing the current views of the barriers and enablers to mainstream schooling and will enable stakeholders in the local area to strategically

review provision and practice for all children across the City. It would have deepened the analysis to have a sample of children in mainstream school and their caregivers who were not at risk of school exclusion so that views could be compared. However, this was not the remit of this commission. It is hoped that the evidence provided in this and the other four commissioned publications, will support TfC in working with all schools in the City to provide a high standard of education for all children.

6. Recommendations

6. Recommendations

The recommendations in the report are intended to enable the local area to develop expertise and capacity in schools, to allow children to thrive emotionally and socially. Some schools need to challenge their current policies and practices, working alongside caregivers, children and multi-agency professionals to better understand the holistic needs of children who find school a barrier to learning. Implementing these recommendations will require a shared commitment.

The first two recommendations were created collaboratively by the advisory group of 12 children in KS2-4 who had experienced exclusion from school.

Recommendation 1: We think isolation booths should be removed from all schools as they do not work and don't improve behaviour but make it worse.

Recommendation 2: We need smaller class sizes in mainstream schools. Thirty in a class is too noisy; there is too much distraction and teachers can't give us the help we need. This will help us learn.

The following recommendations are from the interviews, conversations and advisory group comments.

Recommendation 3: Governing bodies must work with senior leaders and SENCOs to embed alternatives to isolation booths that are based on child-centred approaches. This needs to include training, so there is a clear understanding of the need to apply the graduated approach of: 'assess, plan, do and review' (DfE, 2015a) to identify, understand and respond to children's needs through evidence-based practices.

Recommendation 4: Schools should access training to reinforce their reasonable adjustment duties as legally required by the Equality Act, 2010 and obligations within the Children and Families Act, 2014. These need to be made explicit in school policies such

as SEND, safeguarding, equality, behaviour/discipline, positive handling, mental health and looked after and previously looked after children.

Recommendation 5: Schools should access training on alternative and child-centred approaches to restraining children. For example, Studio 3's Managing Challenging Behaviour course (MCB) accredited by the British Institute of Learning Disabilities. This needs to include the impact of traumatic adverse childhood experiences (ACEs) on children's mental health and wellbeing.

Recommendation 6: For stakeholders in key stage 2, secondary education and TfC to explore the adoption of a vocational education and training model for children who have aspirations outside of academic routes and/or who find the current curriculum stressful and unmanageable. With agreement from the caregiver and child, there should be consideration of continuing the primary education model into years 7 and 8 for children who have been identified as needing an alternative route within secondary mainstream education.

Recommendation 7: Review of health services pathways, including the introduction of a health and support services triage service in Sunderland for children across the child and adolescent years. This would ensure that a decision is made by a health professional about which pathway is most suitable for the child or young person (e.g., paediatric disability service, community CAMHS or CYPS, or other support services). This will need to include a review of the procedures for responding to caregiver concerns at the two-year progress check.

Recommendation 8: To immediately revoke the CAMHS special circumstances list so that all children can access timely support.

Recommendation 9: Children on the edge of, or allocated, a fixed-period or permanent exclusion should be referred to health services to determine any underlying genetic, learning disability or neurodiversity causes.

Recommendation 10: To provide training to health visitors to ensure there is consistency in how teams recognise and respond to the caregivers' voice when they share concerns about their child's development and/or behaviours.

Recommendation 11: To create a crisis response team as part of the CYPS to be available to schools from 8am until 5pm to allow for issues arising before, during and after school.

Recommendation 12: Further consideration needs to be given across the health services of the consequences applied when a child either fails to attend an appointment, or when a child is unable to communicate during the meeting. This should be led by the paediatric disability consultants, as they were commended for their procedures and practices.

National recommendation: The Department for Education (DfE) must take steps to address the use of isolation booths in schools. They should review guidance on the use of this method of sanction and commission case studies of alternative child-centred approaches.

I am grateful to all the participants who have taken part in this research and openly shared their experiences. Thank you for your time and your stories; you have been honest and sincere and this will allow the local area to move forward with research-informed evidence. I would particularly like to thank the children and caregivers; being able to hear from you directly has been fundamental to this research. You are all brave and inspirational, and I wholeheartedly wish you the best life.

7. References

7. References

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